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ABSTRACT

This report reviews the essential medical facts concerning Acquired Immune Deficiency Syndrome (AIDS), the legal implications of AIDS in the school setting, and school board policy responses to AIDS. The report begins with an introduction that clarifies the extent of the problem posed to schools by AIDS and identifies the kinds of information with which school leaders should be acquainted. The next section of the document reviews the medical facts, establishing what AIDS is, what is being done to fight it, and who gets it; citing recommendations from the medical community concerning persons with AIDS in the school setting; and noting the importance of educating the public about AIDS. Legal factors are considered in the document's next section. These factors include the impact of federal laws and regulations on responses to AIDS; the findings in court cases involving AIDS in schools; state laws; and individual rights. The final section of the report discusses school policy problems posed by AIDS and provides examples from the policies of districts throughout the nation. Advice on policy development is also provided. (PGD)

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VOLUME 1

AIDS and the Public Schools



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AIDS and the Public Schools

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AIDS and the Public Schools

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Foreword

It is not stretching credulity to say that AIDS is perceived by most people—rightly or wrongly—as the leprosy of the 20th century. Thus, it will continue to generate enormous, emotion-laden controversy in school board meeting rooms across the nation as the numbers of students and employees afflicted with AIDS increase.

The legal and policy dimensions of AIDS, in the context of the public school setting, are multi-faceted: (1) the school-age child or district employee who suffers from (or perhaps has been exposed to) infection by AIDS; (2) other students; (3) teachers and administrators; and (4) society at large.

A school-age child has a right—and, where compulsory education laws are operative, a legal duty—to attend public schools. How does his having AIDS (or even having been exposed to AIDS, in some cases) affect this right? Can the child be excluded from school because he suffers from a loathsome disease? Can he be exempted from school because his medical condition makes him a threat to the health of his classmates?

And what about his fellow students? If they are infected with AIDS, when the school authorities knew or reasonably should have known about the admission of the AIDS-afflicted or exposed classmate, what liability will the school district have toward his fellow students?

What about the teachers and administrators who work with the AIDS-afflicted child or staff member? If they develop AIDS, will the school district be liable to them, in addition to the usual sick leave and workers compensation? To what extent? Can employees afflicted with AIDS be allowed to continue regular employment when they might endanger fellow employees or students? Can a healthy teacher or administrator be required to work with AIDS-afflicted or exposed students or fellow staff members? Does a school have an obligation to warn students and teachers that a particular student or teacher suffers from AIDS? Converse-

ly, what about the right of the afflicted individual to privacy?

Then there is a larger dimension—society as a whole. What should our societal public policy be in dealing with the AIDS-afflicted student or employee? How much is really medically known about AIDS? Is it enough to predicate a policy that balances compassion with safety, good sense with caution, an individual's right to privacy with the right of others to know of an unhealthy condition, and medical certainty with a lack of knowledge that can lead to hysteria?

What assurances can be given that healthy children, in the ordinary course of playing and working together or being in the same area or handling the same things as an AIDS-afflicted child, will not catch the disease? And what about society's stake in the future of the AIDS-afflicted child? How can such children be productive and avoid being a charge upon the state (albeit with a shortened life span) without an education? And what about the child's distraught parents—how do they, individually or together, figure in the whole dilemma?

These are only a few of the questions that legitimately may be posed about AIDS and the public schools. Nobody has authoritative answers yet. But barring a stunning medical breakthrough in the frantic effort to find a cure for AIDS, the problem—its tough public, personnel and student attendance policy choices—will have an impact upon school board governance for a long time.

* * * *

The primary objective of this report, *AIDS and the Public Schools*, which grew out of a national conference on AIDS in February of 1986 sponsored by NSBA's Center for State Legislation, School Law and Public Policy, is to provide school board members with:

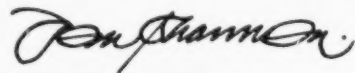
- a comprehensive review of the medical facts known about AIDS;
- information about the legal implications of AIDS in the school setting; and

- an overview of possible school board policy responses to AIDS taken by school districts across the nation.

Please be aware, however, that in this publication NSBA is not engaged in rendering expert medical or legal advice. Should you require expert legal or medical advice, please consult an attorney, or a medical professional qualified in this area.

As always, we welcome your comments and suggestions.

Very truly yours,



Thomas A. Shannon
Executive Director
National School Boards Association

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Introduction

The presence of students and employees with acquired immune deficiency syndrome, or AIDS, is no longer a remote possibility but rather a painful reality for school districts. As of June 23, 1986, the federal Centers for Disease Control (CDC) had received reports of 21,915 cases of AIDS in this country, of which 308 cases involved children under the age of 13. Out of the total number of cases reported, 12,008 persons, or 55 percent, have died. The CDC expects that, within a year, there will be twice as many reported cases of AIDS in the United States.

Facing the Facts about AIDS

The AIDS syndrome, caused by a virus, is characterized by a breakdown in the body's immune system, which in healthy individuals fights off illnesses. Medical researchers have determined that the virus that causes AIDS is transmitted by intimate sexual contact, intravenous injection of drugs with a hypodermic needle that has been used by an infected person, transfusion of blood or blood products contaminated with the virus or by an infected mother to her fetus or newborn child. In the five years that researchers have been studying data related to AIDS, they have found no cases in which the virus has been transmitted by casual contact.

Currently there is neither a cure for AIDS nor a vaccine against the virus, and the mortality rate for persons who developed AIDS more than three years ago is between 75 and 85 percent. In part because of this, health officials say, the public's concern about AIDS in the schools has exceeded that generated by any other disease in recent years, including polio.

The fact that nearly three-quarters of persons with AIDS are male homosexuals or bisexuals and 17 percent are intravenous drug abusers also con-

tributes to public anxiety, as does the perception by the public that scientists and doctors understand little about the disease. An October 14, 1985 story in *The New Republic* termed the fear surrounding the disease "A.F.R.A.I.D.S."—for "acute fear regarding AIDS."

But whatever its roots, the public's fear of AIDS (also referred to as "AIDS panic") has obscured the medical profession's call for a balanced approach to the disease from all levels of society, including schools, employers, health insurance companies, relatives, co-workers and friends of AIDS victims. Fear of AIDS has also crippled the spread of one of the most important pieces of information about the syndrome: that the virus that causes AIDS, although deadly, is relatively hard to catch. The possibility of spreading that virus through casual contact such as occurs in a school or social situation is "remote," according to medical researchers—or, as one medical expert has said, "beyond remote possibility of probability."

Although many local school officials might like to think, "It can't happen here," cases of students or teachers with AIDS have already been recorded in districts as geographically diverse as Miami, Florida; Kokomo, Indiana; Montgomery County, Maryland; Swansea, Massachusetts; Springfield, Missouri; and New York City. Because of misconceptions about how the disease is spread, the presence of a person with AIDS in a school has led to community protests and even school boycotts in some districts.

Parents of school-age children often want to take no chances with their children's health by having them attend school with persons who suffer from AIDS—no matter what the medical experts say about the lack of risk of transmission of the virus through casual contact. Thus school officials are caught between the Scylla of wanting to minimize any possible health risks for the majority of their students and the Charybdis of giving

the students with AIDS the opportunity for education they are by law required to receive.

In the last decade, only herpes—an incurable skin disease caused by a virus that at times is highly infectious but is believed not fatal except in some newborns—has raised similar concerns among parents, teachers and other school officials. As with AIDS, school district leaders' decisions to admit students afflicted with herpes have raised a public outcry in some areas of the country. School district officials have at times found themselves scrambling to develop policies concerning AIDS or herpes only after a student or teacher has been afflicted—instead of being prepared ahead of time.

What School Leaders Should Know

Recommendations for admitting students with AIDS to school, and for responding to cases of AIDS in the workplace, already exist at the federal and state levels. The Centers for Disease Control, for example, has released both school and workplace guidelines for persons with AIDS. The American Academy of Pediatrics has issued guidelines for admitting students with AIDS, as have the health and education departments of several states, including Connecticut and Minnesota. Both educators and health professionals have stressed, however, that final development of policies for local school districts must necessarily be a local responsibility.

Those school district officials who have already responded to cases of persons with AIDS in their schools have stressed the need for cooperation among a wide variety of groups, including: school board members, school administrators, superintendents and principals, local health officials, parents' groups, and the media. Such cooperation, these officials suggest, can help check an epidemic that is spreading through society more rapid-

ly than the virus that causes AIDS—AIDS panic.

Preventing AIDS panic may not be possible in all situations when children with AIDS are admitted to school. School districts in Swansea, Massachusetts, and Springfield, Missouri, however, are two places where school officials, working cooperatively with public health officials and other local officials, helped to avert panic and keep classes filled after admitting students with AIDS to their schools.

In addition to coping with fears of parents and other students when either a student or a teacher with AIDS is in the school, school officials should be prepared for protests from their staff—especially if officials plan to keep the identity of the person with AIDS confidential.

Doctors argue that, because the virus that causes AIDS is not spread through casual contact, little purpose is served by releasing the identity of the AIDS patient. Furthermore, doctors say, releasing such information may jeopardize the psychological well-being of the AIDS sufferer.

Teachers and other school staff, however, may argue that, in their *in loco parentis* role, they have the right to know which of their students suffers from AIDS—so that they can both assist that child and better protect other students from the spread of the disease. Some employees may also argue that, just as they have a right to be informed of other hazards in their workplace, they have a right to know the origin of the “hazard” of the virus that causes AIDS—whether that person is a student or another employee.

Finally, those favoring design of a curriculum for AIDS education for students may face opposition from both school officials and parents who feel that AIDS education—because it will inevitably involve discussion of sexual practices and drug abuse—is not a subject that should be taught in schools. Communities that have faced opposition from some sectors to sex education classes in the public schools, for example, may find little support for a curriculum on AIDS education. And yet, doctors urge, awareness about how the virus that causes AIDS is transmitted is current-

ly the best defense against the disease, both for school-age children and teenagers, and for adults.

The National School Boards Association's Forum on AIDS and the Public Schools

The National School Boards Association (NSBA) has no policy on students and staff with AIDS in the public schools, and this report is not an attempt to set such a policy. Instead, the report attempts to present the facts about AIDS—as a tragic disease, as a social phenomenon, and as a legal issue.

In an effort to help its members learn more about AIDS, the NSBA held a forum on AIDS and the public schools in Washington, D.C., in February 1986. Speakers—who included Dr. Harold Jaffe, chief of the epidemiology section on AIDS activity for the Centers for Disease Control, and Dr. Anthony Fauci, director of the Institute of Allergy and Infectious Diseases at the National Institutes of Health—attempted to address the medical, social and legal ramifications of the disease. They also answered questions from a panel composed of a teacher, a high school principal, a school board attorney, a member of the Parent-Teacher Association, and a high school student.

This report draws on a wealth of information presented at that conference. It also looks at relevant legal concerns, and shows how some school districts have responded to the presence of students and staff with AIDS in their schools. Finally, the report considers the need for schools to have policies and curricula related to AIDS in place before the disease becomes a heated and divisive community issue.

The Role of Schools and Society

A commentary in the November 25, 1985 issue of *Business Week* concerning AIDS in the

workplace noted that most companies in this country “have yet to come to grips with AIDS. But with cases expected to double in a year, no responsible employer can continue to duck the issue. The peace of mind of future AIDS patients and the stability of a company’s work force depend on setting a fair policy without delay.”

As it is in the business community, so it is with the public schools. Speakers at the NSBA forum agreed that AIDS is an issue with which schools—as educators of children and as employers—must come to terms. School officials who have barred AIDS-afflicted students, and employers who have fired employees with AIDS, have already faced lawsuits in this country. And since some researchers now estimate that, at the earliest, it will be several years before an AIDS vaccine reaches the market, the opportunity for such lawsuits may well increase if sound policies are not developed.

That AIDS “is a serious and an extremely complex issue doesn’t have to be emphasized to this audience,” Dr. Louis Z. Cooper, of the department of pediatrics at St. Luke’s-Roosevelt Hospital in New York City, told the NSBA forum. “The issue goes truly to the heart of our value system. It not only is a scientific challenge, but it’s an extreme challenge to [the] community’s capacity for conflict resolution, and from our own experience [in New York City] I’ve come to use it as one of the measures of the levels of trust and distrust within and among communities.”

In the absence of a vaccine or a cure, Dr. Cooper and other forum speakers stressed, education about and prevention of the spread of the virus that causes AIDS are society’s strongest weapons—both against the disease and against AIDS panic. The role of the schools thus is vital in the fight against AIDS, the speakers emphasized, for two reasons. First, schools can serve as examples for the rest of society by developing well-reasoned policies for students and staff with AIDS, based on sound medical evidence. Second, schools can help prevent the spread of AIDS and AIDS panic by educating staff, students and parents about what the disease is—and what it is not. ■

AIDS: The Medical Context

"At the very least, AIDS will be a major presence in many lives for the rest of this decade, if not for the rest of this century."

—The Harvard Medical School
Health Letter,
November, 1985

What is AIDS?

Acquired immune deficiency syndrome (AIDS) is a medical term used to describe the variety of illnesses a person may suffer after being infected with a type of virus that attacks and cripples a crucial element of the body's immune system.

The task of the immune system is to fight off microscopic disease-causing agents. People with AIDS are described as having "suppressed" immune systems because the virus that causes AIDS has left their immune systems incapable of combatting these disease agents, which can include bacteria, parasites and other viruses.

Persons with healthy immune systems, on the other hand, are able to resist many of the diseases agents they are exposed to in their environments.

"Acquired" means that AIDS is not an inherited condition, such as hemophilia; instead, a person contracts AIDS through exposure to the virus that causes it. "Immune deficiency" refers to the fact that the body's immune system is rendered ineffective by the virus that causes AIDS. "Syndrome" refers to the fact that AIDS is characterized by a collection of maladies, which can include types of cancer and pneumonia,

severe diarrhea, and neurological problems.

Doctors in the United States first noticed the occurrence of two of those illnesses now most commonly associated with AIDS—a type of pneumonia known as *pneumocystis carinii* and a type of cancer called Kaposi's sarcoma—among young homosexual men in California and New York between the fall of 1980 and the spring of 1981.

Prior to this time, doctors had seen cases of *pneumocystis carinii* pneumonia almost exclusively among patients with suppressed immune systems, including persons born with defects in their immune system and persons undergoing certain forms of medical therapy, such as chemotherapy, that can suppress the immune system's response.

Kaposi's sarcoma was known to physicians as a skin affliction primarily in elderly men, for whom it was rarely fatal. The appearance of these diseases in young homosexual men who previously had enjoyed good health was puzzling to the medical community.

Officials at the federal Centers for Disease Control, who study the spread of epidemics, first gave the name "acquired immune deficiency syndrome" to this collection of illnesses in 1982. At that time, the CDC noted in its *Morbidity and*

What is AIDS?

Acquired Immune Deficiency Syndrome

Not an inherited medical condition, such as hemophilia. Instead, a person contracts AIDS by exposure to the virus that causes it.

A lack of immunity, or protection, against disease. The virus that causes AIDS attacks the immune system and renders it ineffective.

A collection of symptoms and maladies that characterize a disease. AIDS patients, because they lack immunity against disease, often suffer from several different illnesses. ■

Mortality Weekly Report that "an average of one to two cases [of AIDS] are now diagnosed every day" and that nearly 80 percent of reported AIDS cases in this country are concentrated in the six metropolitan areas of New York, New York; San Francisco and Los Angeles, California; Miami, Florida; Newark, New Jersey; and Houston, Texas. At that time, researchers still did not know what caused AIDS.

HTLV-III/LAV or The AIDS Virus

In 1983 researchers at the Pasteur Institute in Paris, France, identified the virus that can cause AIDS in a person, and gave it the name lymphadenopathy-associated virus, or LAV. ("Lymphadenopathy" is the medical term for swollen glands, or lymph nodes, which have been observed in AIDS patients.)

In 1984 researchers at the National Institutes of Health in Maryland identified a similar virus, which they labeled HTLV-III, for human T-cell lymphotropic virus type III. (The name HTLV-III/LAV refers to the type of immune system cell that the virus attacks.)

These two viruses are now believed to be variants of the same virus; thus, the virus that causes AIDS is commonly referred to as HTLV-III/LAV. The virus is also called ARV, for "AIDS-related virus" and recently, HIV, for "human immunodeficiency virus." Still other scientists call it the AIDS retrovirus, or AIDS virus.

Viruses can be spread in many ways, including through the air and through water. But although the AIDS virus has been found in such body fluids as saliva and tears, researchers at the CDC believe that it can be *transmitted* only by blood or semen. The CDC's November 1985 recommendations for preventing the transmission of the virus in the workplace state:

"HTLV-III/LAV has been isolated from blood, semen, saliva, tears, breast milk, and urine, and is likely to be isolated from some other body fluids, secretions, and excretions, but epidemiologic evidence has implicated only blood and semen in transmission."

Medical researchers currently estimate that approximately one

million people in this country have been exposed to the AIDS virus and are considered infectious; that is, capable of transmitting the virus to others.

Exposure to the virus comes in one of three ways: through intimate sexual contact with a person carrying the virus, through blood or blood products contaminated with the virus, or from an infected mother to her infant, either before or shortly after birth. To date, the CDC has recorded no cases of HTLV-III/LAV being transmitted through casual contact. However, not all of those persons who have been exposed to the virus develop AIDS. The CDC currently estimates that between 15 and 20 percent of infected persons will eventually develop the disease, but researchers as yet have no way of predicting who those people are.

Efforts to determine who among infected persons gets AIDS and who does not are complicated by the fact that the incubation period for AIDS—that is, the time between infection with the virus and onset of symptoms—has been shown to be anywhere from a few months to longer than five years.

The virus called HTLV-III/LAV helps prepare the way for AIDS by destroying certain types of white blood cells that help protect the body against disease. The cells the virus attacks are called helper T-cells, because they help other immune system cells produce the antibodies that fight the microscopic disease-causing agents.

Dr. Anthony S. Fauci of the National Institutes of Health, who spoke at the NSBA forum, has described the helper T-cells as the "focal cell of the immune system." In patients with AIDS, he explained at the NSBA forum, the "virus selectively knocks out this helper cell and the whole immune system collapses."

Recent research indicates that the AIDS virus may also attack other cells in the immune system, in addition to the helper T-cell, and that the virus can directly affect the central nervous system—the body's regulator of mental and physical functions.

Although the virus that causes AIDS can be devastating to an infected person, medical researchers

stress that it is not transmitted through casual contact between persons. The virus is transmitted in humans in one of four ways:

- by intimate sexual contact with an infected person that allows for the semen or blood of the infected person to enter the bloodstream of the non-infected person.
- by intravenous injection of drugs with a hypodermic needle that has been used by an infected person and therefore is contaminated with the virus.
- by the injection of blood or blood products contaminated with the virus, as with blood used in transfusions or blood-clotting products used by hemophiliacs.
- by an infected mother to a fetus or newborn child.

The Symptoms of AIDS

The majority of individuals infected with the AIDS virus experience no symptoms, medical experts say, and some of those who do experience initial symptoms never go on to develop the serious illnesses that signal AIDS. When symptoms first occur, they may be mistaken for those of a simple cold or flu. The symptoms associated with AIDS, however, usually do not go away, doctors warn. These symptoms include:

- prolonged, unexplainable fatigue;
- recurring fevers, chills or "night sweats" lasting longer than a few weeks;
- loss of appetite or recent unexplained weight loss greater than 10 pounds;
- unexplained swollen glands lasting longer than two months;
- a persistent, unexplained dry cough;
- persistent diarrhea;
- a thick, whitish coating or white spots on the tongue or throat; and
- discolored lesions or growth on the skin or mucous membranes (inside the mouth, nose or rectum) that gradually increase in size.

The U.S. Public Health Service advises that anyone with these symptoms should consult a physician.

Opportunistic Infections

The symptoms associated with the early stages of AIDS can be a sign of

the "opportunistic" illnesses that many people with AIDS develop. These diseases are called opportunistic because the agents that cause them take advantage of the "opportunity" provided by the crippled immune system to invade and take root in the body. Again, some diseases experienced by persons with AIDS are virtually unknown to persons with healthy immune systems. And those diseases that also afflict healthy individuals are much more severe—even life-threatening—in AIDS patients, because people with AIDS have no immune defenses to combat the disease.

AIDS patients can develop infections caused by fungi, parasites, bacteria and viruses as well as certain malignancies. The most common opportunistic diseases among AIDS patients are those which first led to identification of the syndrome in 1982: *pneumocystis carinii* pneumonia, a type of pneumonia caused by a parasite, and Kaposi's sarcoma, a rare cancer of the blood vessel walls that appears on the skin and can spread to the internal organs. About 85 percent of AIDS patients have had one or both of those diseases, according to the New York State Department of Health.

In addition, the person with AIDS is subject to severe infections from the cytomegalovirus, which in AIDS patients can result in inflammation of the retina, blindness, colitis, pneumonia, and eventually death. AIDS sufferers are also prey to a rare bacteria—similar to the one that causes tuberculosis—that can cause severe infections in the respiratory system. Other infections and parasites can produce severe, prolonged diarrhea and weight loss in AIDS patients. Infections of the central nervous system can lead to a wide variety of neurological problems for AIDS patients, including dementia, or loss of brain function.

Mortality figures from the CDC paint a grim picture of the outlook for AIDS patients, the CDC's Dr. Harold Jaffe told the NSBA forum.

"The proportion of cases who have died goes up and up as we look at older patients," he said. "For patients diagnosed most recently, about 30 percent are known to have died.

The Language of AIDS

AIDS	Acquired Immune Deficiency Syndrome. A medical term that refers to the variety of severe infections and malignancies a person may suffer from after being infected with a virus that attacks and cripples a central element of the body's immune system.
AIDS Virus	Another way to refer to the virus—called HTLV-III/LAV, ARV, or HIV—that causes AIDS.
ARC	AIDS-related complex. A less severe, but still serious, form of infection with the virus that causes AIDS. Patients with ARC may suffer from weight loss, chronic fatigue, fever, and chronic swollen glands. Some ARC patients progress to the severe illnesses of AIDS; others do not.
ARV	AIDS-related virus. Another way to refer to HTLV-III.
Asymptomatic Carriers	In discussions about AIDS, a term used to describe persons with the virus that causes AIDS, but who have no symptoms, although they are believed capable of transmitting the virus to others.
HIV	Human immunodeficiency virus. A term developed by medical authorities in 1986 to refer to the HTLV-III/LAV virus.
HTLV-III	The name given to the virus that causes AIDS by U.S. researchers in 1984. HTLV-III stands for human T-cell lymphotropic virus, type III, which refers to the type of immune system cell the virus attacks.
HTLV-III/LAV	The common medical term for the virus that causes AIDS. It combines the French and American names for the virus.
Immune System	The body's strongest internal defense against disease agents such as viruses, parasites and bacteria. Cells in the immune system produce antibodies to fight these disease agents.
LAV	The name given to the virus that causes AIDS by French researchers in 1983. LAV is an abbreviation of Lymphadenopathy-associated virus. Lymphadenopathy is the medical term for swollen glands, which many AIDS patients have.
Opportunistic Diseases	Diseases that take advantage of the "opportunity" provided by a crippled immune system to invade a body. Persons with AIDS suffer from opportunistic diseases.
Suppressed Immune System	An immune system that, for whatever reason, has lost its natural ability to combat disease-causing agents that invade the body. Persons with AIDS have suppressed immune systems. ■

When we go back to cases diagnosed more than two or three years ago, we're looking at mortality figures that are in the range of 70 to 80 percent, or even higher."

AIDS patients who contract opportunistic infections such as *pneumocystis carinii* pneumonia survive an average of six months, while AIDS sufferers with Kaposi's sarcoma live an average of 17 months after diagnosis, accord-

ing to Dr. Merle Sande of San Francisco General Hospital, who spoke at a recent AIDS scientific research symposium in Washington, D.C.

AIDS patients die because of the suppression of their immune system, Dr. Jaffe told the NSBA forum, adding, "We are not aware of any patient with diagnosed AIDS whose immune system has spontaneously returned to normal."

Prospects for a Vaccine and Cure

AIDS is a frightening medical condition not only because of the serious, life-threatening illnesses that are associated with it; but because two of the strongest medical weapons against diseases—a vaccine and a cure—do not yet exist for AIDS.

Vaccination gives a person immunity against a disease by introducing a weakened amount of the disease agent—a vaccine—into the body. In response, some immune system cells produce antibodies, a type of protein molecule specifically designed to attack and neutralize that disease agent. Following vaccination, antibodies against the disease agent remain in the bloodstream for years, providing protection against the disease.

Vaccination mimics the process that occurs naturally in the body when a disease agent invades. A successful childhood bout with a virus such as measles, for example, generally gives a person immunity against measles because the antibodies that fought off the measles virus remain in the body to provide continued protection.

AIDS virus vaccine research has been complicated in part by the fact that although people with AIDS have antibodies to the AIDS virus in their blood, these antibodies appear to provide no protection against the disease. One area of research has suggested that the virus that causes AIDS may move directly from cell to cell in the body without passing through the bloodstream, where it would be detected by these antibodies. One researcher, Dr. Jay Levy of the University of California at San Francisco, has theorized that the virus may enter the body already bound to cells in fluids such as semen, rather than as a free virus that must travel through the bloodstream to reach a cell.

Development of a vaccine against the AIDS virus also has been difficult because the outer protein coating of the virus "varies somewhat" from one strain to another, according to Dr. Fauci of NIH and thus a vaccine that protects against one strain of the virus might be useless against another strain. To combat this, some researchers

are directing their efforts against the areas of the virus that do not change, in the hopes of developing a vaccine useful against all strains of the AIDS virus.

Third, AIDS vaccine research has been slowed because HTLV-III is a type of virus known as a "retrovirus." According to a spokesperson at NIH, "Research has never developed a vaccine against a human retrovirus."

Although many retroviruses exist that infect animals, science currently knows of only two other retroviruses that attack humans, each of which—like the AIDS retrovirus—infects a type of white blood cell. The two other human retroviruses are human T-cell leukemia/lymphoma virus (HTLV) type I, and HTLV type II which has been found in a patient with a type of leukemia known as hairy cell leukemia.

Disease agents prevail in the human body because of their ability to reproduce and multiply. Like all viruses, retroviruses can only reproduce inside living cells. Viruses that successfully invade a cell cause the cell not to replicate other cells like itself, but to use some of its genetic replicating materials to produce other viruses. Retroviruses differ from other viruses in the materials and processes they use to replicate within their host cell.

All viruses carry with them their own genetic "code" materials that allow them to replicate, in the form of the substances DNA (deoxyribonucleic acid) and RNA (ribonucleic acid). Most viruses replicate by transferring, or "synthesizing," the necessary genetic information from DNA molecules to RNA molecules, with the assistance of the host cell's enzymes, ribosomes, and other cell genetic manufacturing materials. Retroviruses, however, transfer this genetic information from RNA molecules to DNA molecules and back to RNA molecules, using reverse transcriptase, a special enzyme contained within the retrovirus.

The prefix "retro" thus refers to the extra step such viruses take to replicate, through the use of reverse transcriptase.

Although no vaccines against the retroviruses that attack humans exist yet, AIDS vaccine researchers were somewhat encouraged by the successful development a few years ago of a vaccine against the feline leukemia virus, a retrovirus found worldwide that causes fatal diseases similar to AIDS in pet cats. But although scientists perceive this vaccine as an important model that may help in the development of an AIDS vaccine, they nonetheless point out that the progress of the feline leukemia virus in cats is far from identical to the progress of the AIDS virus in humans. In addition, federal safety requirements governing development of human vaccines are much more strict than those governing development of animal vaccines and, as such, tend to slow development of human vaccines.

As vaccine research progresses, other researchers are developing medical treatment strategies for those persons who already have AIDS. This research is concentrated in three primary areas: development of substances called antivirals, that attack the virus within the body; development of agents to restore the immune system, which are called immune stimulators; and development of more effective treatments for the opportunistic infections and cancers that plague AIDS patients.

Many researchers believe that any successful treatment strategem would have to use a combination of therapies, because even if the virus could be destroyed within the body, an AIDS patient would still be left with a crippled immune system. And no matter how successfully an AIDS patient with a damaged immune system is treated for one opportunistic infection, other diseases can quickly take hold and flourish.

Antiviral research has concentrated on interfering with one of the steps necessary for genetic replication of the virus within the cell, especially on inhibiting the action of the viral enzyme, reverse transcriptase.

One type of immune stimulator research involves the use of interferon, an antiviral substance occurring naturally in the body that now can be produced commercially. In-

terferon, which has been effective both in stimulating the immune system and in fighting cancer tumor activity, has been used with some success on AIDS patients with the cancer Kaposi's sarcoma. In some studies, interferon has been used in combination with chemotherapy on these types of AIDS patients.

In other studies, AIDS treatment researchers are testing the effectiveness of a variety of drugs, including antibiotics and antiparasitics, against severe, life-threatening opportunistic infections that afflict AIDS patients.

These vaccine development and treatment strategies for AIDS currently are being pursued by scientists and doctors at the National Institutes of Health, and at university medical centers and other hospitals around the country. Experts caution, however, that progress is expected to be slow in both areas.

But although currently there is no cure for AIDS, one doctor who treats AIDS patients bristled when it was suggested to him that treatment for those patients in the terminal stages of their infection is "futile."

"I wince when I hear that," Dr. Gerald Friedland, director of medical services at Montefiore Medical Center in New York City and a researcher in the transmission of HTLV-III/LAV, said at a symposium on AIDS sponsored by *Harper's Magazine* in 1985. "I spend most of my time treating patients; to say we have no cure is not to say we do nothing. We are unable to cure many diseases, so we concentrate on palliating them. We do many things to improve the quality of life of AIDS patients. Every day we learn more about how to recognize the opportunistic infections early and treat them effectively."

The Federal Budget for AIDS

The medical fight against AIDS has been helped by substantial increase in the AIDS budget of the federal Department of Health and Human Services (HHS) over the past five years. HHS, the agency which oversees NIH activities, anticipates expenditures in the areas of AIDS research and education of \$233.8 million in the fiscal year that ends

September 30, 1986, of which \$134.7 million, or 58 percent, is directed towards AIDS research at NIH.

HHS's fiscal 1986 budget for AIDS projects represents an increase of 115 percent over the AIDS budget the year before. In 1982, the first year that HHS included funding for AIDS studies in its budget, the total amount allocated was \$5.6 million, of which 61 percent, or \$3.4 million, went to NIH.

From 1982 to 1986, HHS's AIDS budget has increased by more than 40 times, and now includes a variety of research and public education efforts.

A Diagnostic Test for AIDS?

Currently there is no simple diagnostic test to determine if a person has AIDS. According to material from the San Francisco AIDS Foundation, AIDS is diagnosed "by finding a life-threatening illness that would not be found in a person with a fully functioning immune system" in whom other causes of immune system dysfunction, such as chemotherapy, have been "ruled out."

In 1985, the federal government approved a test to detect antibodies to the AIDS virus in donated blood for use by blood banks, other blood collection agencies, and manufacturers of blood products such as clotting agents. The blood test—a type called an ELISA, for enzyme-linked immunosorbent assay—was introduced as part of an effort to "clean up" the nation's blood supply, since about three percent of AIDS patients, including some hemophiliacs, have contracted the disease from contaminated blood used in transfusions or from contaminated blood products.

Blood with antibodies to the AIDS virus is considered potentially infectious and is discarded. Six months after the test was introduced, the Food and Drug Administration, which approved the test for sale, reported that the use of the test "is successfully preventing the virus responsible for AIDS from entering the blood supply."

Use of the test with people, however, has proven more problematic. The ELISA test was originally designed only for use by blood col-

lection agencies to monitor the purity of blood. Because blood collection centers usually notify donors if their blood has tested positive for the presence of the antibodies, however, it has "evolved" into a test that gives admittedly limited information about a person's exposure to the AIDS virus, according to one NIH spokesperson.

But physicians and health officials give several reasons why such information is of limited value and why the test cannot be used to diagnose AIDS in a person.

In the first place, a test result indicating the presence of antibodies could mean either (1) that a person has been exposed to the virus and is now immune and not infectious, (2) that the person is infected with the virus but has not yet developed symptoms of AIDS, or (3) that a person has AIDS—three very different results.

In addition, the presence of antibodies does not indicate whether a person will get AIDS or not. As has been shown, medical experts now estimate that only 15 to 20 percent of persons who have been infected with the virus will eventually develop AIDS.

Last, the test is not infallible, and has been known to indicate the presence of antibodies when there are none (which is called a "false-positive" result) or to declare a sample free from antibodies when they are present (a "false negative" result).

In spite of these reservations, however, health officials urge that persons with a positive test that has been confirmed by two repeated tests (including a "Western blot" type of test, which is more definitive than the ELISA test) should consider themselves infectious—that is, capable of transmitting the AIDS virus to others—although they themselves may never develop AIDS or any related symptoms.

And with increasing frequency, public health officials have suggested that confidential, voluntary testing of individuals in high-risk groups may be one way to help prevent the spread of AIDS.

As part of a five-year plan for prevention and control of AIDS developed in June of 1986, the federal Public Health Service (PHS) recommended that "testing of persons whose behavior places them at risk should be encouraged and made widely available."

The PHS report, titled *Public Health Service Plan for the Prevention and Control of AIDS and the AIDS Virus*, explained that, "In all communities, appropriate medical care encompasses offering counseling and testing to all persons at risk, including persons with a sexually transmitted disease, IV drug abusers, and persons seen in private practice who engage in high-risk behaviors." Anonymous testing, "should be available as an option," according to the report.

Last fall, the New York City health department offered its own reasons why some persons might want to have their blood tested for the presence of antibodies to the AIDS virus. In a report on AIDS prepared for the city's schools, health department officials suggested that, although the results are of admittedly limited value, "There are some circumstances...in which HTLV-III antibody test results might be desirable, as they may influence important decisions in an individual's life."

For example, the report suggests, those persons "who are relatively certain that they are not at risk for AIDS but who are worried that they could be at risk because of a single or rare prior sexual experience, a blood transfusion, organ transplant, or accidental puncture with a contaminated needle may seek the test to reassure themselves." In addition, the report advises, "People who are considering pregnancy and are at risk for AIDS may seek the test to ascertain their risk status and, if positive, defer pregnancy until more is known about the risk to their babies."

But in the face of medical experts' cautions, evidence that the test would be used for purposes other than for which it was originally intended began to accumulate a few months after its introduction, raising questions of civil rights and protection of medical confidentiality.

In October of 1985, for example, spokesmen for the country's armed services announced that all 2.5 million men and women in their ranks would have their blood tested for exposure to the virus, in spite of criticism that the new policy was a misuse of the test. Reportedly, the Defense Department is testing recruits for AIDS because military personnel routinely receive a variety of inoculations which could be dangerous to anyone carrying the AIDS virus.

Recruits who are confirmed to have the antibodies in their blood will be rejected from service; current military personnel who test positive for the antibodies will be put on limited duty, counseled, and have their health monitored, armed services officials said.

In addition, some insurance companies have attempted to use test results to deny health or life insurance coverage to persons who test positive for the presence of antibodies to the AIDS virus.

In response to what they consider are improper uses of the ELISA test results, some AIDS patient-advocate groups and civil rights organizations have argued that individuals should not take the test or even donate blood unless appropriate counseling mechanisms are in place to help them understand the test results, and unless the confidentiality of those results can be guaranteed.

In some areas of the country, these groups have been assisted in their efforts by the passage of city laws or state legislation. In May of this year, the city council of the District of Columbia passed a bill that prohibits health and life insurers from denying coverage to anyone on the basis of a positive test for the presence of antibodies to the AIDS virus. California passed similar legislation in 1985; Wisconsin prohibits use of such tests for insurance purposes until state health officials approve one as medically significant.

Who is Afflicted?

More than 22,000 cases of AIDS have been recorded in the United States since the CDC began keeping statistics on

the disease in 1981, and more than 12,000 have died from the disease. The CDC currently receives reports of approximately 1,000 new cases each month, and officials there predict that by early 1987, the number of cases reported will be "roughly double" those reported by the beginning of 1986. All fifty states, along with the District of Columbia and Puerto Rico, have reported cases, according to the federal Public Health Service, as have 35 other countries.

Geographically, cases of AIDS in this country are still concentrated in the areas where the disease was first identified: 35 percent of all cases are reported from New York state and 23 percent are from California, according to the Public Health Service. New York City alone is home to almost one-third of all AIDS patients in this country, and almost one-half of all identified children with AIDS, according to Dr. Cooper, the pediatrician with St. Luke's-Roosevelt Hospital Center in New York City, who spoke at the NSBA forum on AIDS. Cases from New Jersey, Florida, and Texas account for another 18 percent of all U.S. AIDS cases, states Dr. Jaffe of the CDC.

Risk Groups

By observing who has been afflicted with the syndrome since it was first discovered in 1980, researchers have developed six "risk groups" for AIDS; that is, those groups of people within the population who are at greatest risk for contracting the disease.

Homosexual or bisexual men and intravenous (IV) drug abusers make up the two largest groups of adults at risk for contracting AIDS in this country. Approximately 73 percent of reported cases of AIDS have been homosexual or bisexual men, while 17 percent have been intravenous drug abusers, according to the CDC.

At the NSBA forum, the CDC's Dr. Harold Jaffe noted that there is "considerable overlap" among persons in the two largest risk groups. For example, about 12 percent of all reported homosexual or bisexual men with AIDS also have been intravenous drug abusers, he said. (CDC report-

AIDS in Other Countries

In some other countries, however, groups at greatest risk for contracting AIDS are different from those in the United States, and may include heterosexuals—a fact which can contribute to public apprehension about the disease and how it is transmitted, according to Dr. Anthony S. Fauci of the National Institutes of Health (NIH). At the NSBA forum on AIDS, Dr. Fauci attempted to address these fears by discussing the incidence of AIDS in certain African countries, where many persons afflicted with the syndrome are heterosexual.

"The difficulty and the misunderstanding that is usually prevalent is that, when we talk about different modes of transmissibility, people then jump to the conclusion: 'Well, then, it's transmitted casually, or by the respiratory route,' he said. 'Even in Africa, there is no evidence whatever that it's transmitted within households by anyone other than sexual partners or mothers to their infants.'"

In the U.S., the ratio of males to females with AIDS is 15 to 1; in central Africa, according to Dr. Fauci, the ratio is 1 to 1. But the difference in groups at risk for AIDS in Africa is not evidence that the disease can be casually transmitted, Dr. Fauci stressed. Rather, it points up the fact that an infectious disease may appear to behave differently in two different countries simply because customs and social mores differ in those countries: not because the disease agent behaves

one way in country A and another way in country B.

For example, a "significant proportion" of single female hospital workers in Kinshasa, the capital of Zaire, have antibodies in their blood to HTLV-III/LAV, the virus that causes AIDS, Dr. Fauci said. The reason for this could be sexual contact with infected persons, he suggested. But it could also be due to a medical custom widely different from that practiced by clinicians and hospital workers in this country.

"[In] these countries in Africa, it is not at all uncommon to share needles in the medical environment," Dr. Fauci said, "needles that are actually used for injections in clinics."

Reuse of intravenous needles—a practice virtually unknown in U.S. medicine—increases the risk for the spread of infection not only among patients, but also among hospital workers, Dr. Fauci suggested. A needle used to inject a solution into the vein of an AIDS patient can become contaminated with the virus when it comes into contact with the blood in that vein. For this reason, doctors urge, all hypodermic needles should be discarded after each use.

The blood supply in some African countries may be another reason for the differences in groups at risk for developing AIDS, he noted. "Almost surely, because of the lack of testing and the difficulty in recognizing early on that this infection was prevalent in the society, [blood transfusions] are

likely one cause of transmission" in some central African countries, he said.

The practice of anal intercourse is another factor that may contribute to the high incidence of AIDS among central African heterosexuals who are not drug abusers, some researchers have suggested.

Statistics on AIDS from other countries also support the view that habits and customs peculiar to a country can determine the size of risk groups for AIDS in that country. At a forum on AIDS sponsored by *Harper's Magazine* in 1985, one participant noted that, in Canada, the number of intravenous drug abusers with AIDS is "very low," as compared with the number of intravenous drug abusers in the United States.

Allan M. Brandt, an assistant professor of history of medicine and science at Harvard Medical School, maintained that the difference is due to the fact that in Canada "sanitary needles are widely available," whereas in the United States "addicts share needles—and transmit disease—because it is so difficult to obtain [needles]."

But no matter how customs among countries may differ, Dr. Fauci suggested, the four means of transmission of the virus that causes AIDS remain the same: blood or blood products, intravenous drug abuse, an infected mother to a fetus or newborn child, or intimate sexual contact. ■

ing rules require that a case with more than one of the identified risk factors be placed in the larger reporting group, Dr. Jaffe said.)

"It's presumably this overlap between these two populations that allowed the virus to spread from one to the other," Dr. Jaffe explained at the forum.

"I think . . . that [it] is now very clear that the virus is being sexually transmitted at a high rate in this population and that the risk of transmission clearly increases along with the number of sexual partners and participation in certain sexual

practices," Dr. Jaffe told the NSBA forum.

Intravenous drug abusers comprise the next highest category at risk for acquiring the virus that causes AIDS, because many of them share hypodermic needles during injection of drugs.

Because the AIDS virus is present in the blood, a person who is infected with the virus can contaminate a hypodermic needle with the virus by inserting it into his vein.

Two other groups at risk for contracting AIDS or the virus that causes AIDS are persons'

who receive blood transfusions and persons who have hemophilia, an inherited disorder in which the blood does not clot properly. About two percent of persons with AIDS acquired the virus through a transfusion of contaminated blood; another one percent are hemophiliacs and other persons with blood coagulation disorders who acquired the virus through a contaminated blood product called blood clotting factor.

Heterosexuals whose sexual partners are in one of the risk groups mentioned above constitute another group of persons at risk for acquiring

AIDS. Members of this "heterosexual contact group," as it is known to researchers, make up about one percent of all reported cases of AIDS.

Infants born to infected mothers constitute another one percent of all persons with AIDS. Because children have different risk factors for developing the disease, they will be discussed separately in this report.

The CDC classifies the origin of the remaining six percent of AIDS cases as "other or unknown." About two-fifths of these cases are persons born in Haiti who are now living in the United States, Dr. Jaffe told the NSBA forum. As in some African countries, medical conditions in Haiti—including the re-use of unsterile needles in medical procedures and the use of contaminated blood for transfusions—allow for the spread of the disease. In addition, he suggested, transmission of AIDS among heterosexuals is much more common in Haiti than in the U.S.

Others in the "other or unknown" category include patients who died before they could be interviewed, but who may have been in one of the risk groups; people who were infected through heterosexual contact without realizing it; or people who may not actually have had the disease, according to Dr. Jaffe. He stressed, however, that none of these patients are known to have acquired the virus that causes AIDS through casual contact with an infected person.

In the five years since the disease was first identified and cases reported, researchers note, the percentage of people in each risk group has remained approximately the same nationwide, in spite of the growth in the number of cases.

The 1985 introduction of the ELISA test to screen blood and blood products for antibodies to the AIDS virus is expected to eventually reduce the number of persons who acquire the syndrome from contaminated blood or blood products. The change will not be noticeable for a number of years, however, because the disease's long incubation period means many recipients of blood transfusions and blood clotting products may be infected but as yet experience no symptoms of the disease.

AIDS, ARC, and Asymptomatic Carriers

Medical experts have established three categories of persons who are infected with the AIDS virus: those with AIDS, those with AIDS-related complex (ARC), and asymptomatic carriers.

Those persons with fully manifested AIDS constitute the smallest of the groups of people that scientists estimate have been infected. As Dr. Jaffe said at the NSBA forum, they are "only the tip of a much larger iceberg." The cases in this category must meet a definition for the disease developed by the CDC for reporting purposes. To qualify as an AIDS case under this definition, a patient must have certain severe, life-threatening, opportunistic infections or malignancies, coupled with a suppressed immune system for which there is no other known cause.

CDC officials estimate that there are currently an additional 150,000 persons, who suffer from "AIDS-related complex," also known as ARC. Patients with ARC experience serious symptoms such as weight loss, diarrhea, fatigue, chronic fever, and immune system abnormalities such as swollen lymph nodes—but without "those profound infections or tumors that individuals with full-blown AIDS have," according to Dr. Fauci of NIH. Some patients with ARC progress to AIDS, others do not. Some studies suggest that between two and 25 percent of patients with AIDS-related complex develop AIDS.

At the bottom of the iceberg of patients infected with the AIDS virus are the estimated one million persons in this country who are called "asymptomatic carriers" of the virus. These persons are called asymptomatic because they experience no symptoms either of AIDS or of AIDS-related complex. They are considered carriers because they have been infected with the virus and therefore are believed capable of transmitting it to others.

As we have seen, between 15 and 20 percent of asymptomatic carriers are expected to develop AIDS. The rest—even though they may never develop any symptoms—currently are

considered "infectious for life" by medical experts.

The presence of so many asymptomatic carriers—many of them unaware that they are harboring the AIDS virus—is of great importance in considering the spread of the virus throughout the country, forum speakers stressed. Although protests have been lodged concerning persons with AIDS in some schools or businesses, the speakers noted, asymptomatic carriers are more apt to be the ones to transmit the virus, for two reasons.

First, because they may not know they are infected, asymptomatic carriers are less likely to take precautions to prevent the spread of the virus if they engage in activities such as intimate sexual contact or intravenous drug abuse.

Second, medical researchers believe that asymptomatic carriers may actually be more infectious—that is, have more virus to transmit—than AIDS patients in the advanced stages of their disease, because as the immune system is destroyed, the AIDS virus is left with fewer cells in which to replicate.

Prevention of AIDS

In February 1986 the Public Health Service released the following recommendations for reducing the chances of contracting or transmitting AIDS:

- Do not have sexual contact with persons who are known to have, or are suspected of having, AIDS; who are known to be, or are suspected of being, carriers of the virus; or who have a positive result on the HTLV-III antibody test.

- Do not have sex with multiple partners, or with persons who have had multiple partners (including prostitutes). The more partners that you have, the greater your risk of contracting AIDS.

- Do not inject illicit drugs. If you do inject drugs, your risk may be lessened by not sharing needles or syringes.

- People at increased risk for AIDS should not donate blood, organs, or sperm.

- Women who are sex partners of risk group members or who inject drugs should consider the risk to their babies before pregnancy. These women should have an HTLV-III

antibody test before becoming pregnant. If they elect to become pregnant, they should have the test during pregnancy.

Children with AIDS

Although AIDS is a deadly disease, the CDC, along with many state education and health departments, have recommended that most children infected with the virus be allowed to attend school. Parents and school officials accustomed to routinely keeping children out of school for such common but mild childhood illnesses as chicken pox may have trouble understanding why children infected with the more deadly AIDS virus can sometimes attend school.

The answer lies in the way the virus that causes AIDS is transmitted. At the NSBA forum, Dr. Jaffe of the CDC pointed out that although both AIDS and measles are communicable diseases, the virus that causes measles is easily transmitted through casual contact, while the virus that causes AIDS is not.

The measles virus is communicable through the air, by people coughing and sneezing, he pointed out. The virus that causes polio is present in the feces of infected individuals, and can thus be spread through contaminated water such as that in a swimming pool. The virus that causes AIDS, on the other hand, is what doctors call a "bloodborne" virus; that is, blood is the medium by which it is transmitted. And even among the group of "bloodborne" viruses, Dr. Jaffe pointed out to the NSBA forum, the virus that causes AIDS is considered much more difficult to transmit than another bloodborne virus: hepatitis B.

The AIDS virus is transmitted only by the kind of intimate sexual contact that allows blood or semen from an infected individual access to the bloodstream of another person; the injection of contaminated blood or blood products; by injection using a hypodermic needle that is contaminated with the virus; or from a mother to her child at birth or shortly thereafter, according to medical experts.

None of these activities are likely to occur in a supervised school setting, doctors have said.

Afflicted Children

Children under 13 comprise more than 75 percent of all cases of AIDS currently reported among children under 19 years of age in this country.

As of June 23, children under age 13 accounted for 308 of the 400 cases of AIDS reported in children age 19 and under.

These children do not fall into the same groups most at risk for acquiring the AIDS virus as do older adolescents and adults, CDC officials say.

Children in this age group (12 and under) are at greatest risk for developing AIDS if they are born to a mother who is either infected with the virus or is a member of one of the six adult risk groups (for example, a mother who is an intravenous drug abuser, or a hemophiliac, or a recipient of a blood transfusion, or who has been a sexual partner of a member of one of the risk groups).

Current figures from the CDC show that 77 percent of cases of AIDS reported in children under 13 were the result of transmission of the virus from an infected mother to her child, either before or shortly after birth.

Pediatricians who treat children with AIDS have reported that the majority of their cases involving transmission of the virus from mother to child occurs with mothers who use intravenous drugs, or whose sex partners use intravenous drugs or have homosexual contacts.

Children who receive blood or blood products are the second largest group of children under 13 at risk for receiving the AIDS virus. Approximately 20 percent of all reported cases of AIDS in children under 13 resulted from injection of contaminated blood or blood products. Of those cases, three-quarters are children who received a contaminated blood transfusion; one-quarter are hemophiliacs who received a contaminated blood clotting product.

Between 1981 and mid-1986, the CDC recorded 292 cases of children under age 13 with AIDS in the U.S.

at total, 187, or 61 percent, had died by June 23, 1986.

Approximately 60 percent of all pediatric AIDS cases are black children; 20 percent are Hispanic children; 19 percent are white children; and one percent are children of other or unknown ethnic backgrounds.

Children 13 to 19

The CDC has received reports of 92 cases of AIDS involving children between the ages of 13 and 19. (Mortality figures for this group were not available from the CDC.) Children in this age group are at risk of acquiring the virus that causes AIDS in the same way as do adults: that is, by certain types of intimate sexual contact with an infected person, by sharing contaminated needles during intravenous drug abuse, or by receiving an injection of contaminated blood or blood products.

According to Dr. Martha Rogers, a specialist in pediatric AIDS with the CDC, however, the percentage of teenagers with AIDS in each of the six adult risk groups differs from the percentage of adults over 19 in each risk group. For example, about one-half of cases of AIDS in persons 13 to 19 result from "some type of" sexual contact, either heterosexual or homosexual, with an infected person, Dr. Rogers said, while nearly 20 percent of all reported cases of teenagers with AIDS have been hemophiliacs. (Nearly three-fourths of adults with AIDS acquired the virus through sexual contact, while adult hemophiliacs account for about one percent of the total AIDS cases.)

Information from the CDC on acquisition of the virus in persons ages 13 to 19 shows that, as of June 23, among the 92 cases reported:

- 48 (or 52 percent) acquired the virus through sexual contact, either heterosexual or homosexual.
- 19 (or 21 percent) are listed as hemophiliacs, who acquired the virus through a contaminated blood clotting product.
- 8 (or 9 percent) are described as heterosexuals with a history of intravenous drug abuse.
- 5 (or 5 percent) acquired the virus through a blood transfusion.

- 12 or (13 percent) acquired the virus through "other" or "unknown" means, including five who were born outside the U.S. in countries with a high rate of heterosexual transmission.

Chances for Survival

As has been shown, the figures from the CDC reveal that the majority of reported AIDS cases in persons age 19 and under involve children under age 13. And, according to Dr. Rogers, approximately 80 percent of all reported AIDS cases in children under age 13 involve children under the age of three. Their chances of survival to school age are slim, according to Dr. Rogers and other pediatric AIDS experts.

Dr. Cooper, the pediatrician from St. Lukes-Roosevelt Hospital Center in New York City, told the NSBA forum that "many" infants born with AIDS "do not become a problem in terms of management for day care or schools because they don't survive to that period."

Infants infected with the virus at birth or shortly afterwards usually develop signs of AIDS before they become a year old, according to a May 1985 report on AIDS in children by Dr. Rogers in the CDC's *Current Issues in Pediatrics*.

The course of the disease differs in some ways for infants as compared with adults. The time between infection with the virus and onset of symptoms tends to be less, for example, which some researchers suggest may be due to the fact that infants lack a fully developed immune system and so have even fewer defenses against the virus than adults do.

According to the New York City Department of Health, "very few" of children born with AIDS "live beyond the age of two or three years."

When reviewing figures on the number of cases involving children with AIDS in this country, then, school officials should keep several things in mind. First of all, health officials have reported less than 100 cases of AIDS nationwide involving children between ages 13 and 19. Of those reported cases, many patients have died and some are too sick to

attend school, CDC officials say. Data for children under thirteen also suggest that the number of school-age children with AIDS in this age group is not great, because many of those cases involve children under age three who are not expected to survive to school age.

Children with AIDS in School

But what about those children who survive? Dr. Cooper told the NSBA forum that some children with AIDS can reach school age either because their illnesses "take a different course" or because they received the virus not as infants but when they were older, through contaminated blood or blood products.

In addition, just as with adults, not all children infected with the AIDS virus have developed the clinical symptoms of AIDS. They may have AIDS-related complex, or they may be asymptomatic carriers. And, as with the general population, researchers estimate there are more children with AIDS-related complex than there are children with AIDS, and there may be more children who are asymptomatic carriers than in either of the two categories of illness.

In a booklet on AIDS prepared for the New York City Schools last October, officials from the city's health department noted that "pediatricians who treat children with AIDS and [AIDS-related complex] estimate that for each child with AIDS, they see three to five children with [AIDS-related complex]."

Children with AIDS, as well as those with AIDS-related complex may have widely different clinical manifestations of the disease, Dr. Cooper suggested. It is this variation among types of illnesses that makes it unwise for school officials to treat all children with AIDS as one entity, he told the NSBA forum.

"If you look at the spectrum of illness from AIDS and you try to relate it to some of the statutes and regulations that all of us work under, with regard to the school setting, these kids fall into different categories," Dr. Cooper said.

"These kids may be well or they may have only occasional illnesses,"

he said. At the same time, he continued, "There are other children who, because of their infection, have episodic illness. These kids are entitled to protection under the law. They're entitled not to be discriminated against. And they're entitled to an appropriate education in the least restrictive environment."

In addition, Dr. Cooper pointed out, there are an unknown number of children in schools today who are asymptomatic carriers of the virus that causes AIDS.

As in the general population, the presence of such children makes efforts to isolate carriers of the AIDS virus difficult for school officials, forum speakers suggested. Although some groups concerned about transmission of the virus in schools have suggested screening all school children with the antibody test to the AIDS virus to determine if they have been exposed to the virus, most members of the medical community advise against such screenings.

Medical experts point out that the limitations of the test currently available make it unacceptable as a tool for screening populations for infections with the virus. The test now available shows only who may have been exposed, not who is currently infected.

More importantly, they suggest, medical evidence can offer no sound reason to remove most infected children from the school setting, even if they could be identified. The possibility of transmission of the virus in the school setting is "remote," these doctors say, because the virus that can cause AIDS is not spread by casual contact.

Planning Ahead

Statistics on cases of AIDS occurring in persons age 19 and under show that schools can play a direct and significant role in preventing the spread among students of the virus that causes AIDS, forum speakers suggested. Many children under 13 with AIDS never reach school age, statistics show. Furthermore, about half of children ages 13 to 19 acquire the disease through sexual contact. These figures suggest that courses about AIDS and AIDS prevention aimed at students in the 13- to

Answers to some questions about AIDS and School-age Children

*From the Connecticut Department of Education
and the Department of Health Services*

Can my child catch AIDS or AIDS-related complex from adults or other children?

Children, like adults, can only catch this disease from intimate sexual contact or blood to blood contact with a person who has the AIDS virus infection. The children who are known to have the disease received the infection from exposure to their mother's blood during pregnancy or in the course of childbirth, from a blood transfusion, or from blood products used in treating hemophilia.

Are there certain precautions that will be taken if a child with AIDS is present in the school?

Schools will not need any special precautions to protect other children beyond their routine procedures for cleaning up body fluids after any child has an accident or injury. The child with AIDS or AIDS-related complex will need protection if there is an outbreak of measles or chicken pox, since the child is unable to fight off or be protected by vaccines against such diseases.

Isn't there the possibility that the AIDS child can cut him/herself (e.g., at recess) and not inform anyone? After all, a five-year-old child cannot understand how serious the implications of this could be. What if the child bleeds in the bathroom and doesn't tell anyone?

19-year-old age group may be one of the best ways to keep many students from acquiring the virus.

Education in this area should focus both on the areas of sexual responsibility and on the problems that result from intravenous drug abuse, experts on pediatric AIDS suggest. In addition, some experts counsel, courses on AIDS and sexual respon-

There is no risk of spread of infection from the blood of a child with AIDS unless that blood is inoculated into another person through a cut that is open to the bloodstream. Teachers monitor activities on the playground and children are taught to report any accidents that may occur. Children often seek care for even very minor injuries.

I, as a parent, believe that I should have a right to know if a child or adult in my child's school has AIDS.

Your concerns as a parent are understandable in light of the conflicting information that has been available on this new illness. Schools must protect each child's right to privacy whether he/she has herpes, leukemia or AIDS. In all cases the risks to the school population are determined by each child's physician and the school medical advisor. Much has been discovered by the medical community in the past few months about the transmission of AIDS. Now that the virus has been found, the means of spread has been narrowed to either intimate sexual contact or blood-to-blood contact. This means the blood or fluid from a cut on a person with the virus would have to be injected into the blood of another person to possibly transmit the disease.

What if my child makes friends with a child with AIDS and, for example, brings the child home to play? Don't I have a right to know that this child has AIDS in the

sibility should include a discussion of the ways in which the virus can be transmitted by a mother to her child during pregnancy.

In facing the issue of AIDS among children in their schools, NSBA forum speakers urged, school leaders should concern themselves not only with providing an education for all students with AIDS but with pro-

event he/she hurts him/herself at my home?

Children playing together is not the kind of contact that will transmit AIDS. The parents or guardians of any child with AIDS or other immune deficiency must consider who needs to know of the child's health problem. Caring for the child after a typical bump, scrape, or bruise should pose no problem if you merely cover any cuts with a bandage, then wash your hands after caring for the child.

Younger children who develop a close friendship with other children their age sometimes like to become "blood brothers/sisters." Usually the children will cut a finger with a pin or knife and join their blood at the point of the wound. Can this even possibly transmit AIDS?

The practice of becoming "blood brothers" presents a risk of spread of a number of infections including those that may be transmitted from germs on the knife or instrument used to make the cut. The practice of squeezing the blood out of the wound to mix with that of the other individual would decrease the potential risk. This practice presents a risk of transmission of AIDS, hepatitis B, etc., and should certainly be discouraged! Even if this practice occurred, the risk of transmission would be very low. Thus far, none of the more than 100 persons having accidental needle sticks from needles recently in contact with blood of AIDS patients have developed infection with the AIDS virus. ■

viding all students with an education on AIDS and AIDS prevention.

AIDS and Casual Contact

The presence of children or staff with AIDS in schools raises a serious question for school of-

ficials: how easily can the AIDS virus be transmitted? Although the deadly nature of AIDS makes the need to ask such a question understandable, medical experts at the NSBA forum emphasized repeatedly that the virus that causes AIDS is not spread through casual contact, such as would occur in a school setting.

"We know that the disease is transmitted by sexual contact, by blood or blood products, and by the transmission from an infected mother to her fetus or newborn. There is no evidence whatsoever that there is transmissibility by any other manner, particularly no transmissibility by casual contact."

—Dr. Anthony S. Fauci, National Institutes of Health, at the NSBA Forum

"Every single researcher, every single scientist who has studied this disease, has come up with the same answer, and that is, this disease is not casually spread," Dr. Mervyn F. Silverman of the AIDS Medical Foundation told the forum participants.

Several studies support the researchers' conclusions, including five separate studies of health care workers who worked with AIDS patients and one study of 101 family members and others who lived with and cared for AIDS patients.

Dr. Jaffe of the CDC noted at the forum that, in the studies of health care workers, a total of more than 1,500 health care workers who worked with AIDS patients had been tested to see if they had antibodies to the AIDS virus in their blood. Included in that group were more than 600 workers who had "known accidents involving exposure to the blood of AIDS patients," the majority of those being people who had accidentally stuck themselves with an intravenous needle they had just removed from an AIDS patient.

Among all of the workers studied, however, researchers found "only two or three who appear to have been infected" through exposure to the virus in the workplace, and those were persons who had "a known needle-stick

or other accident exposure to the blood of AIDS patients," Dr. Jaffe said.

"So, in the very highest-risk situations you can imagine—health care workers being exposed to the blood of known AIDS patients—we still find a rate of infection that is way below one percent," he concluded.

The results of these studies are summarized in the CDC's recommendations for preventing transmission of infection with HTLV-III/LAV (the AIDS virus) in the workplace, published in November 1985 (see the following section of this report). These guidelines also emphasize that the virus that causes AIDS is not transmitted by casual contact.

AIDS is "a bloodborne, sexually transmitted disease that is not spread by casual contact," the workplace recommendations state.

The study of 101 family members and other persons who lived with and cared for AIDS patients is one of several such studies of individuals who lived with but had only non-sexual contact with AIDS patients. In this particular study, Dr. Jaffe noted at the forum, "There was substantial contact. There was sharing of household items such as razors, eating utensils, towels, drinking glasses. There was sharing of household facilities, bedrooms, toilets, kitchens. Family members... assisted AIDS patients...with bathing, dressing, eating. They kissed them. They hugged them."

Yet despite all of this contact, Dr. Jaffe noted, researchers found only one person out of 101 who had been infected with the AIDS virus: a child, whom they determined had received the virus from her infected mother at or shortly after birth (See box, page 17).

Researchers in several such family studies "have been unable to demonstrate any risk of transmission within the family," except for that between sexual partners or from mother to child, Dr. Jaffe said. "Surely the risk of transmission in settings with less intense contact, such as schools, offices and churches, would appear to be remote," he concluded.

Several forum speakers cited the fact that there may be as many as one

million asymptomatic carriers of the AIDS virus in this country as further evidence that the virus is not spread by casual contact.

"Those individuals have casual contact every day with a number of individuals in the workplace," said Dr. Fauci of NIH. And yet, he continued, blood samples taken from persons who are not in one of the risk groups for AIDS show that AIDS "is not a prevalent infection in the general population."

The fact that the AIDS virus is difficult to transmit is what keeps AIDS from being a greater health risk than it already is, researchers have said.

"It's fortunate for all of us that AIDS is so difficult to transmit, or we would have an absolutely horrendous problem," Dr. Jaffe said at the forum.

Because of the large number of undetected asymptomatic carriers of the AIDS virus, medical experts emphasize that isolating most AIDS patients from situations involving casual contact such as schools is an ineffective means of controlling the spread of the virus.

"... every single researcher, every single scientist who has studied this disease, has come up with the same answer, and that is: This disease is not casually spread. . . ."

—Dr. Mervyn F. Silverman, AIDS Medical Foundation, at the NSBA Forum

"The public doesn't understand that the patient with AIDS, the person who has the disease, is frequently a person who is less infectious" than the person who has not yet been identified with AIDS or with AIDS-related complex, said Dr. Woodrow A. Myers, the Indiana state health commissioner, at the NSBA forum.

These asymptomatic carriers "may be merrily doing what they've always been doing and will continue to do so until such identification is made," Dr. Myers said. "It's the person who is not identified who engages in [high-risk activities such as intimate sexual contact or sharing IV needles] who is a potential risk."

AIDS Not Spread by Casual Contact

In order to determine if the AIDS virus can be spread through casual contact, a group of researchers from three medical centers in the Bronx, New York, and the CDC studied 101 persons who lived with and cared for—but had no sexual contact with—39 persons with AIDS and AIDS-related complex (ARC). The researchers found that, “despite prolonged and close contact” with patients with AIDS or ARC, all but one of the 101 “household contacts” remained free from infection with HTLV-III/LAV, the virus that causes AIDS. The only person who became infected, a five-year-old girl whose mother had AIDS, was believed to have contracted the infection from her mother before or at birth.

The results of this study, published in the February 6, 1986, *New England Journal of Medicine*, indicate that “household contacts who are not sexual partners of, or born to, patients with AIDS are at minimal or no risk of infection with HTLV-III/LAV,” its authors say.

Of the 101 persons studied, 68 were children under the age of 18 at the time of the study; 21 were children less than six years old. The contacts included children, parents, siblings and other relatives of the patients; 72 were Hispanic, 18 were black, seven were white, and four were in other ethnic groups.

Of the patients, 27 were males and

12 were females; 37 had AIDS and 2 had AIDS-related complex. The majority of the patients—28 individuals (72 percent)—were heterosexual drug abusers. Other patients were homosexuals, sexual partners of persons in the risk groups for AIDS, or those with no documented risk factor for the disease.

All the contacts in the study had lived with an AIDS or ARC patient for a minimum of three months, and had shared “household items and facilities and had close personal interaction” with the patient for a median of 22 months during the period when he or she was presumed to be infectious.

Contacts shared such household items as drinking glasses, eating utensils and plates, towels, combs, nail clippers, and clothing with the infected patients. A small percentage (7 percent) even shared toothbrushes.

More than a third of the contacts shared a bed with the infected patient, and more than 90 percent of the contacts shared a toilet, a bath or shower and a kitchen with those infected.

During their visits with the patients, the researchers noted nearly 80 percent of the household contacts hugged the afflicted patients; 83 percent kissed them on the cheek; and 17 percent reported kissing the patients on the lips.

The researchers noted that, after a

person was diagnosed with AIDS, “most types of household personal interactions [with the infected person] were reduced substantially.” But chances for the infection to be transmitted were present well before then, the researchers pointed out, because AIDS patients are considered capable of transmitting infection for approximately 18 months before symptoms develop that would lead to a diagnosis.

In addition, researchers found “a high percentage” of household contacts—especially parents, siblings and older children—continued to help the patient with “bathing, dressing and eating” after the illness was diagnosed.

“Most of the families in this study were poor and lived in crowded conditions which would be expected to facilitate . . . transmission of infection,” the study found. “In addition, substantial sharing of household facilities and items likely to be soiled with body secretions took place during the period of presumed infectivity, as did the close personal interaction and affectionate behavior expected among family members.”

The results of this study, the researchers write, “should serve to alleviate the fears and concerns of the growing number of household members and other close contacts of patients with AIDS, as well as the population at large.” ■

With respect to school children, Dr. Myers continued, “There are a number of school-age children in the United States who are infected with the virus who are not yet identified, who are potentially capable of spreading the disease if they were to engage in a high-risk behavior or if they were to donate blood. All of which would be extremely unusual in the school-age child in any case, but it would be

especially unusual [for it] to happen in school.”

Finally, the CDC recommendations on education and foster care of children infected with the AIDS virus, which were issued in August 1985, are based on the premise that the virus is not transmitted through casual contact (See page 18 for a summary of these recommendations).

In discussing the risk of transmission of the virus in school, day care

or foster care settings, the CDC states that, “None of the identified cases of HTLV-III/LAV [AIDS virus] infection in the United States are known to have been transmitted in the school, day care or foster care setting or through casual person-to-person contact.”

In addition, the guidelines say, “Other than the sexual partners of HTLV-III/LAV-infected patients and infants born to infected mothers,

none of the family members of the over 12,000 AIDS patients reported to the CDC have been reported to have AIDS."

Recommendations from the Medical Community Concerning Persons with the AIDS Virus in the School Setting

The Centers for Disease Control Recommendations

Recommendations from the Centers for Disease Control concerning the presence of persons infected with HTLV-III/LAV or the AIDS virus in the schools are based on the available evidence that the AIDS virus is not transmitted through casual contact between individuals such as would occur in a school setting. These recommendations apply to all persons with the virus: asymptomatic carriers, those with AIDS-related complex (ARC), and those with AIDS.

Workplace Recommendations

With respect to school staff, the CDC's November 15, 1985 recommendations for preventing transmission of the AIDS virus in the workplace—which primarily address health care workers—also state: "No known risk of transmission to co-workers, clients, or consumers exists from HTLV-III/LAV-infected workers in other settings (e.g., offices, schools, factories, construction sites.) This infection is spread by sexual contact with infected persons, injections of contaminated blood or blood products, and by perinatal [from mother to child before or after birth] transmission. Workers known to be infected with HTLV-III/LAV should not be restricted from work solely based on this finding."

The CDC's guidelines for food service workers infected with the AIDS virus, included in the November report, state that "all epidemiological and laboratory evidence indicates that bloodborne and sexually transmitted infections are not transmitted during the preparation or serving of food or

beverages, and no instances of . . . HTLV-III/LAV transmission have been documented in this setting."

In recommending that employees infected with the AIDS virus not be restricted from working, the CDC workplace guidelines note that many other workplace issues may potentially arise concerning these employees, including: "unwarranted fear and suspicion in some co-workers;" the need for confidentiality of medical records; federal, state or local occupational safety and health laws; and civil rights of employees.

Recommendations Concerning School-Age Children

The CDC issued its guidelines for education and foster care of children infected with the AIDS virus in August 1985. Like the guidelines for employees infected with the AIDS virus, they are based on the premise that the virus is not transmitted by casual contact.

The CDC notes first of all that decisions regarding the kind of "educational and care setting" for the child infected with the AIDS virus "should be based on the behavior, neurologic development, and physical condition of the child and the expected type of interaction with others in that setting."

In other words, the CDC recommends the need for each infected child to be evaluated separately. Decisions concerning placement of the child should be made by a "team" that includes the child's physician, public health officials, the child's parent or guardian and personnel from the proposed care facility or school, the guidelines suggest. In reaching their decision, members of the team should consider the risks and benefits to both the infected child and to others in the proposed setting.

For infected preschool-age children and for some neurologically handicapped children, such as those who lack control of body secretions or those whose customary behaviors include biting, the CDC recommends a more restricted environment such as a setting that "minimizes exposure of other children to blood or body fluids." Infected children who have "uncoverable, oozing lesions" also

should be kept in restricted settings, the agency suggests.

The CDC also recommends regular evaluation of all children infected with the AIDS virus to assess whether they are in the proper environment. As children mature, the guidelines note, their "hygienic practices" may improve; as children's medical conditions worsen, hygienic practices may deteriorate.

Hygienic procedures for handling blood or body fluids should be adopted by all schools, "regardless" of whether children infected with the AIDS virus are present or not, the CDC urges—"because other infections in addition to the AIDS virus can be present in blood or body fluids."

These procedures include cleaning soiled surfaces with disinfectants, rinsing mops in disinfectants, and using disposable towels or tissues "when-ever possible."

The CDC also recommends that care "involving exposure to the infected child's body fluids and excrement, such as feeding and diaper-changing," be performed by people who are aware of the child's infections and the methods of possible transmission of the virus.

Other recommendations of the CDC for officials in schools with children infected with the AIDS virus include respecting the child's right to privacy by maintaining confidential records and telling as few people as possible about the child's condition. The CDC also "strongly" encourages all schools and public health departments to "inform parents, children, and educators" about the AIDS virus and its transmission.

The American Academy of Pediatrics Guidelines

The American Academy of Pediatrics—whose members include more than 29,000 of the nation's pediatricians—issued its recommendations concerning school attendance of children and adolescents infected with the AIDS virus in October, 1985. They are modeled after the CDC recommendations and, like the CDC guidelines, are based on the medical evidence that the AIDS virus is not transmitted through casual contact.

"[T]he possibility of transmission is likely to be extremely low under situations of casual contact and nor-

mal school behavior," the AAP recommendations state.

Like the CDC, the AAP recommends that "most" school-age children with the AIDS virus be allowed to attend school, but notes that some infected students "pose a greater risk than others" and so should be educated separately.

The AAP concurs with the CDC that: (1) there should be regular evaluations of the infected student to assess the level of his or her hygienic practices and the appropriate school setting; (2) "routine" sanitary procedures for handling blood and body fluids should be adopted by all schools, regardless of whether students infected with the AIDS virus are in attendance; and that (3) as few school personnel as possible be aware of the infected child's condition, to preserve medical confidentiality.

The AAP differs slightly from the CDC in recommending that the school district has the primary

responsibility to determine those individuals, including the child's physician, "who have the qualifications to evaluate whether an infected student poses a risk to others." (The CDC does not suggest who has the responsibility of assembling the evaluative "team" it recommends.)

The AAP also suggests that the physician of the infected child should be the one to "regularly assess the risk of school attendance" to the infected child, since the AIDS child may develop deficiencies in the immune system and be at "increased risk" of experiencing severe complications from infections such as chicken pox, tuberculosis and measles.

Children infected with the AIDS virus should not receive live virus vaccines, the AAP says; the CDC notes that vaccination of these children with live virus vaccines "may be hazardous."

Neither the CDC nor the AAP recommend routine screening of children for exposure to the AIDS virus.

Public Awareness of the Facts about AIDS

The public's ability to understand the medical facts about AIDS has been hampered by widespread fears about the disease—some of them based on incorrect or inflammatory reports in the media. Although the medical and scientific communities have learned a great deal about AIDS and the AIDS virus since the syndrome was first named in 1982, the public still perceives AIDS as a "medical mystery," one forum speaker said.

"There's been a lot of discussion over the past couple of years about how little scientists know about this virus," said Dr. Fauci of NIH. "Well, that is really quite a misconception. We know as much about this virus [as] we know about any of the viruses that have been studied for decades and decades. To say that we know very little about this virus is quite incorrect."

The CDC and AAP Recommendations

—NSBA Forum Discussion

Medical experts at the NSBA forum were in agreement with the CDC and AAP recommendations that infection with AIDS virus is not in and of itself a reason to bar a child from school. In addition, they stressed what the two sets of recommendations stress: that each infected child must be evaluated on a case-by-case basis by health and education professionals, both for the sake of his own well-being as well as that of his classmates.

"The Academy's policy and the Public Health Service's policy talk about individualization," noted Dr. Cooper of St. Luke's-Roosevelt Hospital Center, explaining why children need to be evaluated regularly. "A child may be so immunosuppressed [lacking in natural protection against disease] at one time that

he does not belong in class, and another time it is quite appropriate [for him] to be in class. And that's one of the criteria for being in school: is a child under adequate medical supervision, in a responsible family setting, so that his whereabouts can be monitored properly?"

Dr. Silverman of the AIDS Medical Foundation concurred with Dr. Cooper that each infected child must be evaluated separately. He added, however, that in evaluating a child, his or her "mental health" must be considered along with his or her physical condition.

The fact that health professionals recommend that most children infected with AIDS be allowed to attend school, given certain conditions, does not mean that the medical community has turned against the concept of quarantining or isolating, in-

dividuals who have certain illnesses, Dr. Cooper explained to the NSBA gathering.

"No one questions that if we had the misfortune of having an individual with smallpox [an extremely infectious disease caused by an airborne virus that is believed to have been eradicated worldwide] show up in the middle of a classroom, or the middle of a factory, that that person would have to be quarantined until appropriate control measures could take place," Dr. Cooper said. "This country accepts quarantine as appropriate, in selected circumstances."

With AIDS, however, there exists a "broad body" of consistent professional opinion that the way the AIDS virus is spread does not warrant isolation of most persons infected with the virus, he said. ■

Dr. Silverman of the AIDS Medical Foundation noted that gathering information about some deadly diseases has taken centuries.

"Just to put it in context," he told the NSBA gathering, "if we look at the plague, which was first recorded around 1100 B.C., we find that it took almost 3,000 years to define the disease, to understand how it's transmitted, to identify the agent that caused it, and to come up with a cure."

By contrast, he continued, in "four short years," researchers studying AIDS have "come up with the agent, we have learned a great deal about how it's transmitted, we've amassed a wealth of information about epidemiology that tells how the disease is spread, and we also have a test now that will tell us whether a person has been infected."

Doctors at the NSBA forum admitted they sometimes fall prey to bouts of frustration in their efforts to educate the public about what AIDS is and how the AIDS virus behaves.

"I do not understand why we are so unsuccessful at educating people about the disease; I honestly do not understand it," said Dr. Jaffe during the forum's panel discussion.

Much of the frustration researchers feel stems from the public's continuing uncertainty about the ways in which the disease is spread—no matter how much is stated about risk groups, the ways the virus is transmitted and the lack of any evidence of transmission through casual contact.

Such uncertainty, those who have studied the issue say, has its roots in several areas.

In the first place, the public has asked the medical community for *absolute* assurances that AIDS cannot be transmitted through casual contact. Doctors and other scientists, on the other hand, have been trained not to speak in such terms. "There are no absolutes in medicine," said Dr. Silverman at the forum.

As a result, when doctors speak of the risk of contagion, or of any risk in medicine, they always speak cautiously—even if there has been no observed or recorded instance of the risk they are describing. When scientists talk about risk, explained Dr. Cooper of St. Luke's-Roosevelt

Hospital Center, "they are uncomfortable with the words 'always' and 'never.' In fact," he added, "I don't believe I've ever heard any scientist use those terms."

Instead, Dr. Cooper said, "They couch this term of risk within a whole host of qualifying modifiers. I know what they mean, but the press has difficulty and the community has an even greater difficulty" in understanding.

"... scientists in every discipline understand that certain decisions that must be made are associated with some level of risk, but we watch with consternation as society acts as if zero risk could be achieved. The same parents, for instance, who drive their children to school without seat belts demand a flat statement of certainty about the risk posed to their children by being in school with a child with AIDS."

—Daniel E. Koshland, Jr., Editor of Science, in an October 25, 1985 editorial in that magazine on the public's need to develop "scientific literacy"

Several forum speakers, and others who have studied public reaction to AIDS, noted that the public has insisted that the medical community provide the kind of absolute assurances about AIDS that have never been required of other diseases, some of them just as deadly.

"Society is used to accepting risks," Dr. Cooper suggested. "I think it's important... that we not impose a standard on all of us [in the medical community] for this condition that doesn't exist with any other [condition]."

Karolynn Siegel, a forum speaker who is director of research in the department of social work at Memorial Sloan Kettering Cancer Center in New York City, concurred with Dr. Cooper. She noted that "a host of medical conditions apart from AIDS are characterized by limitations on professional knowledge, problems of diagnosis, ambiguity of treatment and outcome, and unpredictability of patient response."

The custom of asking for a second opinion, she pointed out in her

speech to the forum, is a recognition of the limits of the medical professional's powers.

"Despite these facts," she continued, "the public somehow feels it is reasonable to expect certainty in the case of AIDS. They want all pronouncements concerning the safeness or riskiness of different behaviors or circumstances to be definitive and absolute."

The public's inability to accept the facts about AIDS has another origin as well, forum speakers suggested: an increasing mistrust, in this country, of any information disseminated by public officials or any authority figure.

"I think the public does have an inherent distrust in science and medicine—particularly in governmental science and medicine," Dr. Jaffe of the CDC acknowledged.

Ms. Siegel contended that the AIDS crisis has illuminated the "declining trust in government officials" that public opinion polls have documented "in the post-Watergate era."

"As I listened to the news reports last fall concerning whether children should be permitted to attend school, there was often a subtle undercurrent—and often it was explicit—of suspicion of public health officials in many parents' remarks," she said. "It was not merely that they felt the government did not have all the answers; it was also they felt the government might be willing to minimize the hazards of certain policies if it served a larger political purpose to do so."

Such mistrust of health and other public officials is exacerbated by misinformed statements about AIDS made by medical professionals who are not authorities on the disease, speakers said. Dr. Silverman recalled an incident involving a group of physicians—none of them experts on AIDS—who said at a city council meeting of a large Southwestern metropolis that people "should not shake hands with strangers because AIDS can be spread through perspiration."

AIDS and the Media

The news media can play an important role in the effort to curtail the spread of AIDS panic through public education, one forum speaker suggested. But some news stories, instead of curbing fears, have only increased public anxiety about the disease, he said.

"The media is your friend and your enemy, in my opinion, with respect to AIDS," said Dr. Woodrow Myers, the Indiana state health commissioner, at the NSBA forum. The media can be a friend "because it is a very good way to get your message across to the public if the message is presented accurately, [and] if you get the time you need in order to do so."

The news media can be a hindrance to public education efforts in two ways, Dr. Myers suggested. One is the tendency of some reporters and editors to "sensationalize" stories "in order to create tension or controversy." Such stories should not be allowed to go "unchallenged" by school and other public officials, he maintained.

Another problem with conveying information about AIDS through the news media, Dr. Myers suggested, is that the public often receives "only bits and pieces of the entire picture at any given time."

Certain facts about the disease, he noted, "are very difficult to portray in the twenty seconds that one is given on the six o'clock news."

Paul J. Hagerty, superintendent of schools in Springfield, Missouri, described the media's role in his district's successful effort to keep two students with AIDS in school in the January 1986 issue of *The Executive Educator*.

As part of an attempt to develop a "broad base of support" in the community, Mr. Hagerty put together a "carefully planned" news conference to announce the district's decision to admit the two students (without disclosing their identities).

A local cable television station taped the entire news conference and rebroadcast it several times during the period of public interest. Speakers at the news conference included the city's director of public health, the state deputy director of health, and the school board president. In addition to explaining the school board's decision, speakers offered information on how the virus can and cannot be transmitted, and the status of AIDS in the community, Mr. Hagerty said.

In addition, Mr. Hagerty was able to arrange for an "in-depth" newspaper story on the issue, written by a

medical reporter, that ran in the local papers the morning after the news conference. The front-page story was "excellent, comprehensive and objective," he said.

Responding to requests by parents for a meeting after the story broke—but wary of setting up a "large, confrontational meeting"—Mr. Hagerty arranged for a question-and-answer session between P.T.A. presidents and school principals on one side, and medical experts and school administrators on the other, to be broadcast live over the local cable educational access channel, with the opportunity for viewers to call in questions.

The telecast lasted for three hours, with nearly 300 questions coming in through the hot line, Mr. Hagerty said. Like the news conference, this meeting was rebroadcast several times in the next few days.

Following the broadcast, principals reported "business as usual" in their schools, Mr. Hagerty said.

"Things would not have gone nearly so well without tremendously objective and supportive news media," he concluded—as well as "involved and trusting parents, a calm and supportive school board, and an overall commonality of purpose." ■

"If you're sitting there and you're confused about the disease, and a doctor—who you assume has the same knowledge as all the rest who are telling you that it isn't a problem—gets up there and says that, who are you going to believe?" Dr. Silverman asked.

"The problem today is that the only weapons with respect to this disease are education and prevention."

—Dr. Woodrow A. Myers, Indiana state health commissioner, at the NSBA Forum

In considering a controversial editorial written last fall by a prominent neurologist who favored quarantining patients with AIDS, Dr. Cooper commented, "Just because you happen to graduate from school doesn't give you wisdom on everything. An enormous amount of harm is done when people who are experts in one area—and legitimate and justified experts—try to generalize that mantle of experience to other areas."

In spite of the public's apparent resistance to the best efforts of medical experts to provide information about the disease, however, the forum speakers nonetheless agreed that, in the absence of a vaccine or

cure, the only effective weapons against AIDS remain education about the disease and about ways to prevent its transmission. Such efforts, Dr. Silverman suggested, may ultimately stem two epidemics: the disease epidemic of AIDS, and epidemic of fear surrounding that disease. ■

AIDS Hotlines around the Country

CALIFORNIA

Northern California
800-367-2437

Southern California
800-922-2437
Monday-Friday 9 a.m. to 9 p.m.
Saturday-Sunday 11 a.m. to 5 p.m.

FLORIDA

Miami
305-358-HELP
Daily, 24 hours

ILLINOIS

Chicago
312-871-5696
Monday 1 p.m. to 4 p.m.
Tuesday-Thursday 7 p.m. to 9:30 p.m.
Sunday 3 p.m. to 5:30 p.m.

NEW YORK

Department of Health Hotline
1-800-462-1884
Monday-Friday 8 a.m. to 8 p.m.
Saturday-Sunday 10 a.m. to 6 p.m.

New York City
Department of Health Hotline
718-485-8111
Monday-Friday 9 a.m. to 9 p.m.

Pediatrics AIDS Hotline
Albert Einstein College of
Medicine/Montefiore Medical Center
212-430-3333

TEXAS

Houston
713-524-2437
Monday-Friday 9 a.m. to 9 p.m.

U.S. PUBLIC HEALTH SERVICE HOTLINE

1-800-342-AIDS (outside the Atlanta,
GA area)
404-329-1295 (in the Atlanta, GA
area) ■

AIDS: Fears and Facts

For those frustrated in their efforts to get accurate but understandable information on AIDS, the Public Health Service (PHS) offers one solution. "AIDS: Fears and Facts," a 23-minute videotape produced by the PHS, provides answers to many general questions about the disease. Available for sale or through a free loan program, the tape features Dr. James Curran, director of the AIDS program at the Centers for Disease Control, in a question and answer session with a general audience. One of the questions asked concerns children with AIDS in the schools, according to PHS.

"AIDS: Fears and Facts" is available for purchase at \$55 per tape, from:

National Audiovisual Center
8700 Edgeworth Drive
Capitol Heights, MD 20743-3701
Attention: Customer Service

Telephone: 301-763-1896

The tape also can be acquired on a free loan basis from:

Modern Talking Picture Service
5000 Park Street North
St. Petersburg, FL 33709
Attention: Film Scheduling
Telephone: 813-541-5763 ■

The Legal Balancing Act

In addition to grappling with complicated medical facts and troubling social questions, school officials also must consider a variety of legal issues before deciding what steps to take with regard to a student or employee who has AIDS. There are no easy solutions, and legal consequences may await those public school officials who try to address the problem by categorically excluding persons with AIDS from their schools.

Case law in this area is admittedly sparse: few students or employees with AIDS have brought legal actions against school districts. However, a number of federal and state statutes and constitutional provisions may apply.

Relevant federal laws, for example, may include statutes protecting the rights of handicapped individuals, other anti-discrimination laws and statutes, and the Equal Protection and Due Process Clauses of the U.S. Constitution.

State laws that may apply in situations involving persons with AIDS in the schools include communicable disease laws, state laws protecting the handicapped against discrimination, and state constitutional provisions against discrimination.

School district officials should also be aware of such legal issues as the advisability of testing employees and students for the presence of antibodies to the AIDS virus; the rights of other students and employees; and the extent of school board liability for injuries to employees or students that may result from the presence of a person with AIDS in the schools.

A closer look at some of the relevant laws and related cases should shed light on these complex issues.

Federal Laws

Key among the federal laws that school district leaders must keep in mind when responding to persons with AIDS in their schools are those relating to handicapped individuals: the Education for All Handicapped Children Act (EAHCA), also known as P.L. 94-142, (1) and Section 504 of the Rehabilitation Act of 1973 (2).

Education for All Handicapped Children Act

P.L. 94-142 authorizes grants to school districts to educate handicapped children. Districts that accept funding under this act are subject to certain procedural and programmatic requirements, such as the development of an Individualized Education Program (I.E.P.) The I.E.P.—developed by a team that includes teachers, psychologists and the child's parents—includes educational goals for the child, a timetable for achieving those goals, and the specialized educational services to be provided to the child. A basic premise of the statute, and therefore the I.E.P., is a requirement that the child be provided a "free appropriate education" in the "least restrictive environment."

Because P.L. 94-142 is an education funding act and not a non-discrimination act, its definition of "handicap" is based on whether a child needs special education services because of that handicap. The definition of "handicapped children" in Section 1401 of P.L. 94-142 reads as follows:

The term 'handicapped children' means mentally retarded, hard of hearing, deaf, speech or language impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, or other health impaired children, or children with specific learning disabilities, who by reason thereof *require special education and related services.* (Emphasis NSBA's.)

A recent decision from the New York State Supreme Court, Queens County shows how the provisions of P.L. 94-142 can be applied to the question of admitting a student with AIDS to school (3). In this case, a community school board in Queens opposed the decision of the New York City Board of Education to admit a student with AIDS to school. (In New York City, the Central Board of Education has the final say over school policy in the 32 "community" school boards scattered among the five boroughs.)

In its court challenge the District 27 Community School Board argued that the student did not seek admission through the school's committee on the handicapped, as is required under P.L. 94-142.

In deciding against the community board, the court ruled that although a child with AIDS could become handicapped as a result of deterioration in his or her condition, and then be in need of special education services, "the evidence clearly supports the determination that such children are not handicapped for purposes of referral to a Committee on the Handicapped merely because they have AIDS/ARC or are infected with the [AIDS] virus."

Legal opinion thus far, however, has not been consistent on this issue. In a case involving a school district in Kokomo, Indiana, a state hearing examiner held that Ryan White, a child with AIDS, *was* handicapped under the terms of P.L. 94-142, and directed the district to convene its committee on the handicapped to evaluate the youth (4).

It should be noted, however, that the school board in Kokomo did not contest the claim made by the attorney for Ryan White that P.L. 94-142 applied in this case. Had the school board done so, the court might have ruled differently on this issue.

School districts always have the option of using their committee on the handicapped to assist them in making decisions on the treatment of students with AIDS. But in the absence of the need for special educational services, a district should not be required to refer the child to the committee.

Section 504 of the Rehabilitation Act of 1973

Another federal law which may apply in cases involving persons with AIDS in schools is Section 504 of the Rehabilitation Act of 1973. This law forbids discrimination in any "federally assisted program or activity" against any "otherwise qualified" handicapped individual. The definition of "handicapped individual" in Section 504 is broader than that in P.L. 94-142:

[A]ny person who (i) has a physical or mental impairment which substantially limits one or more of such person's major life activities, (ii) has a record of such impairment, or (iii) is regarded as having such an impairment.

Teachers, other school district employees, and students are all protected by the act, because the United States Supreme Court has ruled that Section 504 applies to employees as well as to beneficiaries of federal funding (5). (The scope of coverage of Section 504, however, has recently come into question because of a 1984 Supreme Court decision concerning a similar statute, Title IX of the Education Amendments of 1972. Title IX prohibits sex discrimination in federally funded education programs and activities. In its 1984 decision, *Grove City College v. Bell* (6), the Supreme Court limited the protection of Title IX to the specific part of the program receiving federal funding. However this question is beyond the scope of this discussion.)

When school district officials reach a decision that a child or employee with AIDS is "handicapped" under the terms of Section 504, what legal rights and obligations accompany that decision? A recent lawsuit involving a Florida school district will undoubtedly prove to be the leading case on the question of the application of Section 504 to persons with communicable diseases.

The Arline Case

In *Arline v. School Board of Nassau County* (7), an elementary school teacher challenged the school board decision to terminate her employment after she had suffered three relapses of tuberculosis. In his decision in the case, the federal district court judge in Jacksonville, Florida held that a contagious disease such as tuberculosis is not a "handicap" within the definition of Section 504. The judge explained his decision by saying that "although there is no question that [Ms. Arline] suffers a handicap... it's difficult for this court to believe that Congress intended contagious diseases to be included within the definition of a handicapped person" under Section 504.

The case was then appealed to the U.S. Court of Appeals of the Eleventh Circuit. That court held that since Section 504 is designed to prevent "unnecessary discrimination" against handicapped persons, it would violate the intent of Congress to

allow a handicapped person to be dismissed solely because the person has a contagious disease (8). The appeals court also directed the district court to determine whether the risks of infection precluded Ms. Arline from being "otherwise qualified" for her job and "if so, whether it was possible to make some reasonable accommodation for her in that teaching position, in another position teaching less susceptible individuals, or in some other kind of position in the school system."

The U.S. Supreme Court has granted the school board's petition for review of the case. Although the school board's petition raised several issues, the Supreme Court has agreed to decide only one of those: "Does the contagious, infectious disease of tuberculosis constitute a handicap within the meaning of... Section 504?"

In addition, the Court has raised a second issue which it has asked the parties to the case to address: "Whether one who is afflicted with the contagious, infectious disease of tuberculosis is precluded from being 'otherwise qualified' for the job of elementary-school teacher, within the meaning of Section 504."

Justice John Paul Stevens dissented from the Supreme Court's decision to grant review in the *Arline* case. In dissenting, he wrote that he believed the appeals court had addressed the issue relating to "qualification" for the job when it sent the case back to the district court. Justice Stevens further wrote that the lower court should have been allowed to answer the question raised by the court of appeals related to "reasonable accommodation" before the Supreme Court became involved. The Court is expected to hear the case in the fall of 1986.

Whatever decision the Supreme Court reaches in the *Arline* case will certainly affect the interpretation of Section 504 as it relates to other communicable diseases such as AIDS. There are, however, two important differences between tuberculosis and AIDS: (1) the degree of contagion and (2) the severity of the consequences.

Tuberculosis is contracted by inhaling bacteria carried on airborne droplets released when an infected

person sneezes, coughs, speaks or sings. Thus, one may contract tuberculosis through casual contact with an infected person, such as might occur in a classroom. There is little, if any, risk of contracting AIDS in a classroom environment. However, those who suffer from tuberculosis can be cured and recover, while AIDS is a disease for which there is no cure and from which no one has yet recovered.

In addition to the degree of infectiousness, other characteristics of diseases are relevant to the question of whether a person is "qualified" for a job under the terms of Section 504. Thus, a person with AIDS might be found to be unqualified, not because of the disease's infectiousness, but because of physical or mental limitations that the disease can cause. For example, Dr. Jaffe of the Centers for Disease Control noted at the NSBA AIDS forum that researchers have discovered that dementia, or loss of mental ability, can be one of the side effects of AIDS. Dr. Jaffe suggested that an employee with dementia caused by AIDS should be treated in the same manner as other disabled employees whose disease "would affect his or her ability to carry out their job."

The Department of Justice Opinion on Employees with AIDS

A unique opinion recently issued by the U.S. Department of Justice raises another question: whether "communicability" is a handicap. On June 23, 1986 Charles Cooper, Assistant Attorney General, Office of Legal Counsel, issued a Memorandum for Ronald E. Robertson, General Counsel for the Department of Health and Human Services entitled, *Application of Section 504 of the Rehabilitation Act to Persons with AIDS, AIDS-Related Complex, or Infection with the AIDS Virus*. The memorandum states that a person with "full-blown AIDS" is "handicapped" within the definition of Section 504, but a person who is a "carrier" of the disease is not handicapped solely because of being a carrier.

In its opinion, the Department of Justice does not adopt the position

that a person's "communicability" or "infectiousness" is a characteristic that an employer may legally take into account in determining whether that person is "otherwise qualified" for his or her position. Instead, the Department of Justice argues that an employer is not discriminating on the basis of handicap if adverse action is taken against an employee because of a fear of the employee's contagiousness—even if those fears are unjustified or "irrational."

While the Department of Justice memorandum notes the abundance of research from the Centers for Disease Control and elsewhere relating to the lack of evidence that AIDS can be transmitted in a casual setting such as a classroom, it states that some believe the CDC's conclusions are "too sweeping." As an example, it cites a statement by Professor William Haseltine of Harvard Medical School that "anyone who tells you categorically that AIDS is not contracted by saliva is not telling you the truth There are sure to be cases . . . of proved transmission through casual contact."

What the Justice memorandum does not report is that Dr. Haseltine's remark appeared in a March 18, 1986 editorial piece in *The New York Times*, written by Allen M. Dershowitz of Harvard Law School, and that Mr. Dershowitz subsequently retracted Dr. Haseltine's remark in a letter to *The New York Times* dated April 1, 1986. Mr. Dershowitz's letter reads in part:

Dr. William Haseltine, whose comment I quote in my op-ed article on March 18, has asked me to clarify his current views on the transmission of AIDS. Although laboratory research establishes that it is theoretically possible, as Dr. Haseltine said, for AIDS to be transmitted by saliva and casual contact, epidemiological data strongly suggests that infection has very rarely, if ever, been casually transmitted in this country. Dr. Haseltine urges continued education about the disease.

Dr. Haseltine also contacted the Department of Justice directly, complaining of the references to his comments in the memorandum. Dr.

Haseltine maintained that the *Harvard Crimson's* original reporting of his views contained errors and quotations taken out of context. He explained in a letter to the Department of Justice that his "lecture emphasized that transmission by means other than sexual, maternal, blood transfusion, organ donation or intravenous drug abuse was so low as not to be measurable. Even if documented, such cases would not alter the overwhelming fact that infection is not casually transmitted."

Assistant Attorney General Cooper apologized to Dr. Haseltine, but stated at the same time that the medical issue was "fundamentally irrelevant" to the legal issue the memorandum addressed.

The debate over "theoretical" risk begs the real question of whether the Department of Justice was correct in its legal opinion that an employer is not discriminating on the basis of handicap when adverse action is taken against an employee or applicant because of the fear of contagion.

Thus, a school district which finds itself in court after deciding to fire an employee because of fear of contagion might try to use the Department of Justice's opinion to support its position. Although the opinion might persuade some judges to rule in favor of the school district, the analysis is nonetheless a shaky basis for a school board policy. It is a good example, however, of the type of reasoning which led Shakespeare to suggest in *Henry VI, Part II* that the "first thing we do, let's kill all the lawyers."

As a legal document, the opinion is unnecessarily technical and misses the point that Congress was intending to make when it passed Section 504: to protect handicapped persons from discrimination on the basis of unsubstantiated fear and prejudices.

Non-discrimination statutes traditionally are broadly interpreted by the courts. For example, the Fifth Circuit in a case interpreting Title VII of the Civil Rights Act of 1964 stated:

It is, therefore, the duty of the courts to make sure that the Act and the intent of Congress is not hampered by a combination of a

strict construction of the statute and a battle with semantics. This court has held many times that Title VII should receive a liberal construction. . . . (9)

The Department of Justice cites no legal authority for its opinion that Section 504, unlike other civil rights statutes, is to be narrowly construed. Nothing in the legislative history of Section 504 indicates that Congress intended to prohibit discrimination based on a mistaken belief that a characteristic of the person's handicap impairs his ability to perform the job while allowing discrimination based on a mistaken fear of another characteristic of the handicap, *e.g.* its communicability. The characteristic of the handicap which is seen to impair the ability to perform and the characteristic which renders the person communicable are nonetheless both characteristics of the same disease. Adverse treatment of an individual because of mistaken or irrational belief about either characteristic would constitute discrimination on the basis of handicap.

AIDS is not the only disease that has led employers to act irrationally. There was a time when people thought cancer was "catching," although such a risk has never been considered to be even "theoretically possible," according to medical experts.

It could be argued further that, if discrimination based on an unsubstantiated fear of contagion is not discrimination based on handicap, then adverse treatment based on the irrational fears evoked by other handicaps also does not constitute the type of discrimination prohibited by Section 504. Such fears might include fear of the seizures that persons with epilepsy suffer, fear of the wheelchairs needed by paraplegics, fear of the catheters used by children with spina bifida, or fear of the unsightly appearance caused by craniodiaphyseal dysplasia—the disease suffered by the boy who was the subject of the movie *Mask*.

Under the terms of the Department of Justice opinion, it appears, nearly any adverse treatment of a handicapped employee by an employer can be

justified, simply on the grounds that the employer "fears" certain symptoms or other characteristics of the employee's disease or condition. Under such a legal analysis, the issue of whether or not the employee's major life activities are substantially impaired so that they render the person unable to perform the job is no longer relevant.

With such reasoning, the Department of Justice opinion completely subverts the purpose behind Section 504. As the American Medical Association pointed out in its *amicus curiae* brief in the *Arline* case:

This proposed framework [of the Department of Justice opinion on employees with AIDS] does violence to the fundamental Congressional purpose of Section 504 of protecting handicapped individuals from decisions based on fear, prejudice or stereotype. It also does violence to the statutory language and to the decisions of [the Supreme] Court.

How should school districts treat the Department of Justice opinion? Technically, it is only the opinion of one agency of government. Although the memorandum will certainly have an effect on government civil rights investigations of school districts, the courts are not bound by the opinion, and they may or may not choose to accept its arguments.

In considering the Department of Justice opinion, school district leaders should remember that the opinion addresses only the question of whether employers violate Section 504 by dismissing or refusing to hire employees who the employer believes might infect others with the AIDS virus. The opinion does not mention restraints on public employers—such as school districts—that exist under the U.S. Constitution. Even if one were to accept the Department of Justice's premise that Section 504 does not prohibit discrimination on the basis of irrational fear of contagion, public employers—because of these constitutional restraints—would still not be free to act "irrationally."

For example, an employee who is terminated because of the school district's unfounded fear that the employee is "communicable," may bring suit under the Equal Protection Clause of the U.S. Constitution. The employee's right to pursue this claim in court would exist even if federal government civil rights officials take no action against the school district based on the Department of Justice opinion. An employee also has rights under state tenure laws and the U.S. Constitution's Due Process Clause, under which the school district would have to justify its actions on something more substantial than an irrational fear. Similar protection is afforded students under these laws.

The foregoing criticisms of the Department of Justice opinion on employees with AIDS does not mean that school districts should ignore the communicability of an individual's disease, no matter what the disease, in determining whether or not to retain the employee. As the facts of the *Arline* case show, many serious communicable diseases—unlike AIDS—can be transmitted through casual contact such as could occur in the workplace.

In its opinion, the Department of Justice discusses, as an alternative to its primary rationale, the fact that Section 504 prohibits discrimination against "otherwise qualified" handicapped individuals. The phrase "otherwise qualified" has been interpreted to mean "qualified in spite of" the handicap (10). Thus, if the person is genuinely contagious to others in the workplace, that may well be sufficient reason to declare the person not "otherwise qualified."

It is not clear as to who has the burden of showing "qualification." In its opinion on employees with AIDS, the Department of Justice states that the burden is on the handicapped person to show that he or she is otherwise qualified. The Supreme Court, in its decision in *Arline*, is likely to touch on this issue.

Ultimately the courts will determine the direction school districts may take with regard to treatment of students and employees with communicable diseases. In the meantime, school districts should endeavor to gather sound medical advice on the issues to

assure that decisions are based on rational medical opinions, and not on unsubstantiated fears.

Section 504 and Students with Communicable Diseases

The *Arline* case and the Department of Justice opinion both address situations involving employees with communicable diseases. There are also several cases that specifically address the applicability of Section 504 to students with communicable diseases. In 1979 the Second Circuit Court of Appeals ruled in *New York State Assn. for Retarded Children, Inc. v. Carey* that school officials violated Section 504 by isolating retarded children who were carriers of the hepatitis B virus from the rest of the school community (11).

The court based its decision in part on the school officials' failure to demonstrate that the children carrying the hepatitis B virus posed a health hazard to others with whom they might come into contact. The district court had pointed out that hepatitis B is "transmitted primarily by blood-to-blood contact, by means of transfusion of injected blood, or by use of a contaminated needle, although some experts believe, but have not conclusively established, that it may also be transmitted through body fluids other than blood, such as saliva or semen" (12).

The hepatitis B virus and the AIDS virus have similar characteristics: both are carried in the blood of infected persons and both can be transmitted when blood from an infected person enters the bloodstream of an uninfected individual. Medical research has shown, however, that the hepatitis B virus is far more easily transmitted than the AIDS virus.

The court based its threshold Section 504 decision in the *Carey* case not on the premise that a carrier of hepatitis B was handicapped, but on the premise that only mentally retarded carriers of the hepatitis B virus were isolated. Nevertheless, this case can still serve as an example of Sec-

tion 504 cases relating to AIDS because the court's decision addressed the question of the risk to others posed by virus carriers. The court wrote:

Without requiring that the Board clearly demonstrate existence of a significant health risk, we cannot countenance depriving these retarded children of the benefits to be gained by association with other children, handicapped and non-handicapped, nor can we permit any action which, by its stigmatizing consequences, would irreparably disrupt their educational development. In view of the availability of less drastic prophylactic measures which might be adopted... the proposed segregation seems an unwarranted and unnecessarily restrictive reaction to the purely theoretical risk of transmission that the Board has shown (13).

Not all court decisions call for admitting infected children to the classroom. In an unreported case, *Ely v. Howard County Board of Education*, the U.S. District Court of Maryland, upheld the emergency suspension and ultimate exclusion from a special school for the handicapped of a retarded student with severe learning disabilities who had been identified as a carrier of the hepatitis B virus (14).

In this case there was expert testimony that the child drooled constantly and that, because saliva carries the virus, there was a "high risk" of infection of other students or staff through contact with the child's saliva. There was also evidence that a member of the school staff had contracted hepatitis, apparently from this child.

The court acknowledged the rights of the child to an education "in the least restrictive environment" and the hardship and injury he would suffer by being excluded from school. But it contrasted the child's hardship with the hardship that would be suffered by the board of education (representing other students and school staff) if the child were placed in school, and concluded that the two "are of a different degree and kind."

"The former is undoubtedly a temporary setback to the child in his tragic circumstances," the court wrote. "The latter could be life threatening at the worst, and life debilitating if not life threatening."

The court then continued with a discussion of the question of "risk"—a question that is always present in these cases:

While it may well be that the hygienic precautions, if rigorously followed, would reduce the risk to a minimal one, the defendant's expert believed that the risk was nevertheless significant.

After hearing the evidence the court concludes that the risk is significant to the health and safety of the staff and the other students and believes the probability that [the student will infect a staff member or a student] is so great that the court cannot, in good conscience, say that the risk to the defendants would not outweigh the injury to the plaintiff (15).

Decisions in such cases may turn on the student's personal hygiene habits and level of awareness of his or her medical condition. In a case brought in Illinois state court, the court held that attempts by a school board to place a student with Down's syndrome who was also a carrier of hepatitis B on a home study program violated the "mainstreaming" requirement of P.L. 94-142 (16). Under the mainstreaming provision of the law, the district must place the handicapped child in the "least restrictive environment." In discussing the question of the infectivity of the student, the court noted that, unlike the student in the *Ely* case, the Illinois student was meticulous in her personal hygiene and well aware of her medical condition.

Thus, the legal issues in these cases are fairly straightforward, i.e., a school district cannot discriminate on the basis that someone has AIDS unless it can show that the person poses a hazard to others. The factual issues are more difficult to resolve. One such question of fact is whether an infected individual is capable of spreading disease to others in the school environment and, if so, how

long that individual must be kept out of the classroom. In answering the second part of this question, the school board will be determining whether an employee should be terminated or merely suspended for a short period of time.

AIDS Cases

Two highly publicized cases involve the question of admission of children with AIDS: one in Indiana and one in New York.

The first concerns a 13-year old hemophiliac, Ryan White, of Kokomo, Indiana, who in December, 1984 was diagnosed as having contracted AIDS from a blood product contaminated with the virus.

White v. Western School Corporation

Following the advice of local public health officials, officials at Ryan's school originally barred the youth from attending classes when they learned that he had AIDS. Ryan's mother brought suit against the school district and, after several months of legal wrangling, Ryan was allowed to attend school against the protests of several parents of students attending his school.

Education, legal and medical experts who have studied the Ryan White case have attributed the public apprehension over Ryan attending school both to the public's ignorance of the facts about AIDS and to the apparently contradictory positions taken by public officials about the safety of children with AIDS attending school.

A review of the situation in Kokomo between 1984 and 1986 from information provided to NSBA by school district officials may illuminate some of the legal issues such cases can raise for school districts.

During November and early December of 1984, Ryan was seriously ill and was absent from school for much of that time. Ronald Colby, the principal of Western Middle School, which Ryan attended, was notified in mid-December that Ryan

had been hospitalized with a rare form of pneumonia and was suspected of having AIDS. In early January, 1985, Mr. Colby was notified that Ryan had been diagnosed as having AIDS.

In February of 1985 the school began working on a program of home instruction, but in early March, Ryan's mother informed Mr. Colby that the youth was too weak to do work. At the end of the month, however, Mrs. White informed Mr. Colby that Ryan was much better and wanted to come to school on a day when the school was serving pizza to have lunch with his friends. Mr. Colby informed her that public health officials would have to be contacted and, if Ryan were to visit, the pizza lunch would be held after spring break, the week of April 8.

During this time, Mr. Colby and his staff contacted the state board of education and the local public health department several times for guidance. Officials at the state board of education told Mr. Colby that the local public health department would have to determine whether Ryan could come to school. On April 8, an official of the public health department informed the school nurse that Dr. A. J. Adler, the Howard County Health Officer, had recommended that Ryan not be permitted to visit the school. Dr. Adler based his recommendation on his interpretation of current state health guidelines for dealing with contagious diseases.

On April 12 Mr. Colby contacted Mrs. White and informed her of Dr. Adler's recommendation. In May Mrs. White requested information on home instruction and summer instruction, but later in the month decided that it was too late in the school year to begin home instruction and that Ryan needed the summer months to enjoy his normal summer activities.

During the month of June, Mr. Colby attempted to obtain copies of the state and local guidelines on contagious diseases, including guidelines on AIDS. He also attempted to obtain written confirmation from the local public health department on its recommendation

to keep Ryan White from visiting the school—but he was unsuccessful.

James O. Smith, superintendent of the school district, was responsible for deciding whether to admit Ryan to school in the fall. Mr. Smith knew that the local public health department had advised school officials not to allow Ryan to visit the school for the pizza lunch. He also had heard that the state board of health had delayed issuing its guidelines concerning management of students with AIDS in schools because of uncertainties about what officials at the Centers for Disease Control were going to recommend.

Given the state's uncertainties and the local public health department's verbal advice, Superintendent Smith believed he had no choice but to refuse Ryan admission to school. On July 29 he called Mrs. White and informed her of his decision.

One day later, on July 30, the state health board sent their interim guidelines on management of students with AIDS in the schools to Mr. Smith by express mail, at the same time that it released the guidelines to the press. In the guidelines, the state recommended that most students with AIDS be permitted to attend school, provided that certain protective measures are followed.

On August 8, Mrs. White filed suit against the school district on Ryan's behalf, alleging violations of P.L. 94-142, Section 504 and the Equal Protection Clause of the U.S. Constitution (17). The Whites' lawsuit triggered community opposition to permitting Ryan to attend school. On August 12, a lawyer—purporting to represent a group of some 300 parents—threatened to file a civil suit against the school district if Ryan were admitted to school. Three days later, about 50 teachers voted to support Superintendent Smith's decision to keep Ryan out of school.

A hearing was held on Friday, August 16, in federal court on the Whites' motion for a preliminary injunction. The school district argued that the court had no jurisdiction to hear the case, basing its argument on the Supreme Court

decision in *Smith v. Robinson* (18). In the *Smith* case the High Court held that when a child is "handicapped" under P.L. 94-142, then any dispute about the child's placement must be resolved under that law which requires that administrative remedies be exhausted before a suit can be filed in federal court.

The judge in the Ryan White case agreed with the school district's argument, and denied the motion for preliminary injunction (19).

(Under Indiana law, administrative remedies include the convening of a "case conference" to evaluate the child. In the event of dissatisfaction with the recommendations of the case conference committee, the parties involved have the right to request a hearing before an administrative hearing examiner. They also have the opportunity to appeal the hearing examiner's decision to the Indiana State Board of Special Education Appeals.)

Later on August 16, Superintendent Smith called Mrs. White and informed her that, since school was to begin August 26, the district's case conference committee would be chosen the following Monday to consider the appropriate means of schooling for Ryan. The following week, the committee ruled that the appropriate schooling for Ryan was home instruction through the use of a telephone hookup, a decision that the Whites promptly appealed to an administrative hearing examiner.

During the month of August, Ryan's school worked with the telephone company to have a telephone conference call system installed in Ryan's home, so that he could participate in class by telephone.

On September 3, however, school officials received word that Ryan had been hospitalized. After his release from the hospital on September 9, a teacher in Ryan's school took a computer and printer to his home, but Ryan was too ill to use it until September 16.

From September 24 to November 12, health problems—including weakness and a persistent cough—prevented Ryan from using the telephone system or doing any homework. He was hospitalized for

much of October and November, and underwent surgery in early November. Ryan resumed his home study on November 13.

On November 1, while Ryan was ill, the administrative hearing examiner heard the Whites' appeal. Deciding in their favor, she entered on November 25 an order finding that Ryan was handicapped under P.L. 94-142 due to his hemophilia and AIDS, and that homebound instruction was not the "least restrictive environment" for him. She directed the school district to admit Ryan to school in accordance with the state board of health guidelines on management of students with AIDS in the schools.

At its December 17, 1985 meeting, the Western School Corporation—the local board of education governing the Kokomo schools—voted to appeal the hearing officer's ruling to the state Board of Special Education Appeals.

On February 6, 1986, the Appeals Board determined that "the school acted appropriately in excluding the child from school upon the diagnosis of the AIDS disease." The board held that the hearing examiner had exceeded her authority in ordering Ryan back to school without a certificate from the local health authority, as is required by state statute when a student has one of several communicable diseases.

"Testimony stipulates that AIDS is now considered by the [state] Board of Health as a new communicable disease and is covered under appropriate statute of the state of Indiana," the appeals board wrote. "By statute, the school is required to remove any student from school with such a communicable disease until such time that the school receives a certificate of health from the local health officer, which certifies appropriateness for readmission to school."

Superintendent Smith sent a formal request for such a certificate to Dr. A.J. Adler, the Howard County health officer on February 11. In his request, the superintendent stressed the legal importance of the certificate.

"Since [s]tate law empowers you to make the decisions regarding Ryan's

return to the classroom, the school expects you to accept any legal liability that may result from that decision, and will be required to name you (and the Howard County Board of Health, if they participate in the decision) as a party to any lawsuit arising from Ryan's return to school," the superintendent wrote.

On February 13, 1986, the local public health department in Kokomo issued a health certificate, in accordance with Indiana state board of health guidelines, that Ryan was fit to return school. The certificate stated that "it has been determined that [Ryan's] present medical condition is such that he should not pose any threat to his fellow students, teachers and others." However, the certificate was conditioned on "full compliance" with the state guidelines relating to protective measures.

The state health commissioner, Dr. Woodrow Myers, concurred in the certification "with the understanding that all persons involved strictly adhere" to the guidelines. The school immediately began a series of training sessions for employees and provided students with information sheets on AIDS.

"You all know of children and families whose lives have been totally disrupted; in fact, almost destroyed by community ostracism."

—Louis Z. Cooper, M.D., St. Lukes-Roosevelt Hospital Center, New York City, at the NSBA forum on AIDS, on the issue of medical confidentiality for students with AIDS

Although the guidelines provided general rules for the admission of AIDS students, they did not provide the necessary detail to guide the school in handling the day-to-day problems Ryan's presence might create. Mr. Colby, working in conjunction with the county health nurses, developed specific and detailed procedures to implement the guidelines.

The school admitted Ryan in accordance with the health certificate on February 21. That same morning a group of parents filed suit in state court, seeking an injunction against Ryan and his mother under another provision of the Indiana health code, which prohibits a parent from allowing a child with a communicable disease to attend school. At 5:30 that afternoon, a Howard County Circuit Court judge granted the protesting parents' motion for a temporary restraining order against Ryan and his mother, and Ryan was directed not to attend school the next school day.

In response, Ryan's attorney requested that the case be moved to Clinton County. This request was granted and, on April 10, Clinton County Circuit Court Judge Jack O'Neill vacated the injunction and ordered Ryan to be admitted to school. At 10:30 that morning Ryan returned to school where he completed the remainder of the school year.

The parents of 23 students in the school then removed their children from school, and started a private school for their children in nearby Russiaville.

District 27 CSB v. NYC Board of Education

At the same time that Kokomo, Indiana, was wrestling with the issue of whether to admit Ryan White to school, a similar controversy was raging in New York City.

In April 1985, Charles Schonhaut, the Deputy Chancellor of the New York City Public Schools, requested that Dr. David Sencer, the city's Commissioner of Health, develop guidelines on admission and attendance of children with AIDS in the public schools. At the time, two children with AIDS who were enrolled in the school district were receiving home instruction because of handicaps caused by AIDS.

In May Dr. Sencer informed Mr. Schonhaut that he was convening a committee—under the jurisdiction of the city health department—to develop the guidelines, and he requested that a Board representative be named. Mr. Schonhaut appointed

Dermott Kehoe, his Assistant for Special Education, to serve on the committee. Dr. Sencer also advised the Central Board of Education to continue home instruction for the two children with AIDS.

In its first draft of the guidelines, the committee established a policy of "fully integrating children with AIDS or related conditions into the public schools." During the summer the committee developed several additional drafts, with no substantial changes from the original version.

On August 29, Dr. Sencer received a copy of the CDC guidelines for management of school-age children with AIDS, one day before their official release. According to his testimony during the ensuing trial, Dr. Sencer stated that—based on information he had received during several sessions on AIDS conducted by experts from the CDC and elsewhere—he believed the CDC guidelines were too cautious in their approach to management of children with AIDS in the schools. The health commissioner further believed it was not necessary for schools to convene a panel to review infected children, as the guidelines suggested.

Nevertheless, opting to be more rather than less cautious, Dr. Sencer decided that the non-exclusionary policy in New York's draft guidelines should be augmented by a case-by-case review of children with AIDS by a multi-disciplinary panel jointly appointed by him and by Nathan Quinones, the New York City Public Schools chancellor. Mr. Quinones concurred with Dr. Sencer's decision.

On August 30 New York City Mayor Edward Koch, Mr. Quinones, Dr. Sencer, and James Regan, the Board of Education president, issued a joint statement announcing a policy that children with AIDS would not automatically be excluded from school, but would be reviewed on a case-by-case basis. The policy stipulated that a joint, four-member, multi-disciplinary panel would review the records on each school-age child with AIDS and would recommend the appropriate educational setting for that child.

At the same time, unaware that the city's health department and central

board of education had had the matter under consideration since April, community school boards in two separate areas adopted resolutions to exclude children with AIDS from schools within their jurisdictions.

With the adoption of the community school boards' resolutions, the public confusion concerning the city's official position with respect to admitting children with AIDS to school began to increase. Mayor Koch added to this confusion on September 1 when he publicly stated that, in his opinion, younger children with AIDS should not attend public schools and he believed the newly appointed review panel would support his position.

On September 5 the panel began its review of several cases of school-age children with AIDS. The panel recommended that one seven-year-old child—who had been diagnosed as having AIDS several years earlier but who had remained physically well and had done well in school for three years—should remain in school. The panel also recommended that the identity of this child remain confidential.

The panel recommended further that the other children with AIDS not be admitted to school classrooms, for a variety of reasons not related to their infectivity: the identity of one child had been revealed, one child had been hospitalized because of family problems, and the other children were too ill to attend school.

On September 7, Chancellor Quinones, Board of Education president Mr. Regan, and Dr. Sencer announced the panel's recommendations, and their support of those recommendations.

Following this announcement, two community school boards immediately filed suit against the Central Board of Education. The community school boards sought an injunction ordering the release of the child's name and prohibiting the admission of the child to school (20).

While the trial was underway, Dr. Sencer convened a second panel to review cases of school-age children with AIDS, as a means of verifying the findings of the first panel. This second panel determined that the child attending school who had been previously diagnosed

as having AIDS actually did not meet the CDC definition of AIDS. Instead, the child was infected with the AIDS virus and showed clinical evidence of immune suppression—that is, lack of natural protection against disease.

In spite of the second panel's findings with regard to this child, Judge Harold Hyman of the New York State Supreme Court, Queens County, determined that the case should still be heard, because the city's guidelines still existed and such a situation was likely to occur again. (In New York state, the Supreme Court is a trial court.)

In his opinion in the case, Judge Hyman discussed, and discarded, each of the petitioners' four challenges to the actions the board of education took with respect to admitting children with AIDS to school. These challenges were:

1. The original decision to admit children with AIDS to school.
2. The composition and procedures of the original four-member panel.
3. The adequacy of the special precautions to safeguard other children.
4. The decision not to disclose the identity of the AIDS child.

A closer look at the petitioners' challenges and the court's responses to those challenges may serve as a good example of a legal opinion on the issues involved in admitting students with AIDS to schools.

1. Admission of Children with AIDS

The petitioners—the community school boards—argued in their challenge to this decision that the New York City Board of Education violated the New York City health code which requires exclusion from school of persons with a “communicable” disease “when required to be isolated or excluded by Article 11 of the [city's health] Code.”

Article 11 of the Code sets forth differing restrictions for a variety of different diseases, such as chicken pox, diphtheria, hepatitis, measles, and smallpox.

The court held that, although New York City had designated AIDS as a

“reportable” disease—meaning that doctors are required to report to the city's health department all cases that they treat—AIDS had not been designated by either the city or the state as a “communicable” disease. Thus, the court concluded, the regulations on which the petitioners relied in this challenge were inapplicable.

The court then turned to the general question of whether the Board of Education's action was “arbitrary,” and it concluded that it was not:

[T]he use of broad police power to protect the public health, safety and welfare may to some extent interfere with liberty or property. This is appropriate only where the court determines that the action is reasonably connected to and will in fact promote the public health or safety. The court noted in supporting this point that the city health commissioner testified that he had the “discretionary authority” to exclude all AIDS children from school, but that he did not think that such action was warranted, given the nature of the disease.

The court also noted that the only expert witness to conclude that no children with AIDS should be admitted was an epidemiologist who conceded his lack of knowledge about some of the studies on AIDS in a family setting, which support the conclusion that the AIDS virus is not transmitted through “casual” contact such as that in the classroom. In his testimony this epidemiologist described his disagreement with the CDC guidelines—which recommend admitting most children with AIDS to school, after individual evaluation—as a “philosophical difference” as to the sufficiency of data “at this moment in time.”

The court found that the expert testimony over the five-week trial was fairly uniform on the risk factors and modes of transmission of the virus. These experts agreed that the virus is not spread by casual interpersonal contact or by an airborne route, such as through breathing, sneezing, coughing, shaking hands, or hugging. Most of the experts' testimony “was

addressed to the subject of the so-called ‘theoretical risk’ of transmitting the AIDS virus through exposure of open skin lesions or mucous membranes to the blood of an infected child during a fight, as a result of a nosebleed, or even from the childhood practice of becoming ‘blood brothers/sisters,’” the court said.

Given the “apparent nonexistent risk of transmission of” the AIDS virus in the school setting, the court concluded that a policy which called for *automatic* exclusion of children with AIDS from the regular classroom would “have no adequate connection with the public health, safety or welfare.” While noting his empathy with the fears of parents for the health of their children, nevertheless Judge Hyman concluded that he could not hold the city's action “arbitrary” merely because the “court of public opinion” believes that exclusion is the best policy choice.

Having discussed the question of whether the board was within its discretion to *admit* the child, the court then went on to consider the question of whether the *exclusion* would violate the child's civil rights.

Citing *New York State Assn. for Retarded Children, Inc. v. Carey*, the court ruled that children with AIDS are handicapped within the meaning of Section 504 of the Rehabilitation Act. Further, the court found that, because the petitioners failed to show anything more than a “theoretical risk” of transmission of the AIDS virus in a classroom setting, there was no reason to exclude children with AIDS from school. Even that theoretical risk was reduced by the health measures taken by the Central Board of Education, the court noted.

The court also found that a policy that excludes only carriers of the AIDS virus who have full-blown AIDS, without also excluding carriers with the less severe or no symptoms of AIDS, would violate the Equal Protection Clause of the U.S. Constitution, which prohibits unjustified discrimination. With respect to the issue of screening tests, the court referred to the testimony of medical experts that screening all New York City school children to identify carriers of the

AIDS virus is not advisable, both for social and scientific reasons:

Because of the shortcomings of the antibody test and the social implications of a mandatory screening program, none of the medical experts, including petitioner's expert virologist, recommended blood testing of all New York City school-aged children for the virus to determine whether they should be in school.

The court also held that although "handicapped" under the definition in Section 504, the child did not fit the definition in P.L. 94-142. Although a child with AIDS could become handicapped as a result of medical deterioration, ruled the court, and thus be in need of special education services, "the evidence clearly supports the determination that such children are not handicapped for purposes of referral to a committee on the handicapped merely because they have AIDS/ARC or are infected with the [AIDS] virus."

2. The Composition and Procedures of the Original Four-Member Panel

The court upheld the process used by city officials in developing the guidelines, pointing out that a review panel of city health department and board of education officials considered the available epidemiological evidence on AIDS when making their recommendations as to the placement of children with AIDS.

The court held that the New York City Board of Education based its decision on admission of children with AIDS on the "apparent non-existent risk of transmission" of the AIDS virus in an unrestricted classroom setting. Thus, the board's reliance on the panel's findings as to the children under evaluation was appropriate, the court found.

3. Safeguards for Other Children

In addressing this challenge, the court found that the policies in effect

in the district "conformed, for the most part, to the routine and standard precautionary measures considered by medical experts to be adequate to guard against any possibility of transmission, [and] additional precautions and policies... were implemented to protect against any theoretical risk of transmission of [the AIDS virus] in a school setting by such occurrences as biting or exposure to infection."

4. Confidentiality

The fact that the health commissioner obtained the information about the students with AIDS through supposedly confidential city surveillance data on reportable diseases raised crucial issues concerning protection of confidentiality, the court noted, adding that maintaining confidentiality is in the public interest. The court said the health commissioner came "dangerously close" to compromising the confidentiality of the city health department's surveillance data by using it to identify students for review by the panel.

The court recognized the myriad public policy issues involved in balancing the public's right to know versus the students' right to confidentiality. But it held that the panel which recommends where students with AIDS will be educated should have the final decision as to whether, and to whom, the identity of those students should be revealed.

State Communicable Disease Laws

Challenges to school district decisions to admit persons with AIDS to school are also likely to be brought under state communicable disease laws or other similar public health provisions. The parents' group in the Ryan White case brought their suit under the Indiana communicable disease law; the New York challenge by the community school board alleged violations of the New York state communicable disease law. In deciding whether to admit a student with AIDS or to

allow a teacher with AIDS to continue working, then, school district officials must be aware that such state laws will bear on their decisions.

Virtually every state in the country has some statute regulating the admission of students and employees with communicable diseases to the schools. According to a recent study by the Education Commission of the States, 46 states exclude pupils from regular school attendance because of illness and 25 states exclude chronically ill school personnel from contact with children.

The wording of the communicable disease statutes varies from state to state. Indiana, for example, requires the board of health to certify that a person with a communicable disease is no longer infectious to others. Other statutes, such as that in Virginia, do not discuss "infectiousness" but merely prohibit school officials from admitting persons with diseases which have been declared by the state to be communicable. The statute in Virginia has been interpreted by some school districts as a law enabling them to prohibit the admission of children with contagious diseases such as AIDS, even without proof that the disease is communicable in a classroom situation. It is unlikely, however, that such an interpretation would survive a court challenge.

Nearly all the states have enacted laws directly related to the health of school children. All states except two require immunization of public school students (21). These health laws are enforced notwithstanding compulsory attendance laws which are in effect in all the states.

Even though most states do not have explicit provisions for employees with communicable diseases, a continuing requirement for certification of good health and freedom from disease is commonplace in statutes regarding the health of school employees (22). Generally this type of provision has been upheld by the courts (23).

Among the states with statutes regarding the health of school employees, at least 25 of the states and the District of Columbia require a medical certification that an employee is free from tuberculosis or other communicable disease (24). Another five states do not specifically

require certification that the employee is free from communicable diseases but do make good physical health a condition of employment (25).

Approximately 20 states require employees to undergo examinations subsequent to initial employment either periodically or as ordered by the school board. Most states that require subsequent physical examinations do so on an "as needed" rather than periodic basis. However, certain states still require periodic checkups for their high risk employees (26), and some require periodic exams for all their employees (27). In addition, nine states provide that no teacher can be employed while in the contagious stage of tuberculosis.

Testing Employees and Students for Antibodies to the AIDS Virus

The test to determine the presence of antibodies to the AIDS virus was developed for the purpose of protecting the blood supply. Medical experts do not advise its use for mandatory screening of all employees or students. In the first place, these experts say, it is not 100 percent accurate, and—since it was developed to identify contaminated blood and blood products—may tend toward "false-positive" test results. Secondly, a test result indicating the presence of antibodies could mean one of several different things: that a person has been exposed to the virus and is now immune and not infectious; that a person is infected with the virus but has no symptoms of AIDS; or that a person has AIDS—all very different conditions.

In addition to medical and scientific questions of accuracy involved in screening, there are important legal issues to consider. In any screening process, the employer doing the screening has to show what use is to be made of the results. Are the employees going to be suspended or dismissed, depending on the test results? Are the students going to be removed from the regular classroom?

If there is no medical justification to treat the person differently after registering positive on the test, then there also is no legal authority to invade the person's privacy and conduct the test. School districts are governed by the Fourth Amendment to the U.S. Constitution, which prohibits "unreasonable" searches and seizures, and this type of screening is unlikely to be held "reasonable" in a court of law (28).

Potential Tort Liability

No matter how remote the chances of transmitting the AIDS virus in the school setting, school boards that admit a student or employee with AIDS may later find themselves involved in a lawsuit brought by an employee or student who claims to have contracted AIDS from casual contact in the school with the infected employee or student.

In order to win such a lawsuit, however, a plaintiff will have to prove two difficult legal points. First, it must be proved that AIDS was contracted on school property. Second, even if the first hurdle is met, the plaintiff must then show that the school district was negligent in allowing the infected student or employee to stay in school, or in its supervision of the child.

Although school boards do have a duty to exercise reasonable care to minimize the risk of the spread of any contagious disease, no duty exists to eliminate *every possibility* that a student or teacher will contract a disease from another individual in the school. School districts do not have the duty of an "insurer" (29). That is, although school districts have a duty to provide "reasonable care," they are not *guarantors* of the safety of employees or students.

Cases in which employers or landlords have been held liable to someone who has contracted a disease from others while on their premises have involved highly contagious diseases, such as smallpox. In these cases, the courts have held that the defendant knew or should have known of the danger of contagion and had a duty to warn others of that danger (30).

The fact that the school has knowingly allowed a student or employee with a disease to be in the school, then, is not sufficient to substantiate a case of negligence. The claimant must also prove: (1) by what means the disease was transmitted to the claimant, (2) that the school district should have known of the hazard of that mode of transmission, and (3) that the school district failed to take reasonable steps to avoid disease transmission from the infected person to others.

Given the nature of AIDS and its method of transmission, it would be difficult for a plaintiff to prove that he or she had contracted AIDS through ordinary casual contact such as occurs in the school setting, even if the school district did not institute and follow recommended prophylactic measures, such as those recommended by the CDC. But even those schools that have no employees or students with AIDS should establish such protective health measures to prevent the spread of many other diseases more infectious than AIDS which are commonly found among students and employees.

For example, in a case in Minnesota nearly 60 years ago, a school teacher alleged that she had contracted tuberculosis because the school district had not properly cleaned and disinfected her classroom after the departure of her predecessor, who left her job because she had tuberculosis. Although the court dismissed the action on the grounds that the school district had sovereign immunity, it nonetheless held that the school district had been negligent (31).

A school district that admits or employs a person with AIDS, then, could likely defend itself successfully against a negligence claim brought by an individual who claimed to have contracted AIDS in the school—as long as the process by which the school made its decision to admit the person with AIDS was reasonable. The school district should be free from liability provided that it:

- made its decision to admit the infected person on the basis of available medical knowledge, after
- consulting with health professionals about the safety of admitting

A District Challenge to State Guidelines

New Jersey is one state whose policy on admitting children with AIDS to school has been "put in limbo" as a result of a court challenge by two districts who opposed the state guidelines, a New Jersey education department spokesperson said.

Last fall the state education department, in conjunction with the state health department, issued guidelines stating that all children in kindergarten to 12th grade "who have AIDS, AIDS-related complex, or the presence of the HTLV-III antibody... shall attend school," except for certain children who, for example, cannot control their bodily functions or who have a history of biting.

The guidelines also established a medical advisory panel for review of cases in which the local school physician and the infected child's physician did not agree that the child's behavior merited exclusion from school.

If this panel decided that the child should be in school, the guidelines gave the state commissioner of education power to direct "that the child be admitted to school immediately."

School officials in two separate boroughs, who had opposed Education Commissioner Saul Cooperman's orders, barred infected children from their schools. Officials in the two districts challenged the validity of the guidelines before the appellate division of the New Jersey Superior Court. The districts argued that the commissioner and the state education

department lacked the authority to establish the procedures for admission outlined in the guidelines. In March the court ruled in favor of the districts, striking down the state's guidelines on procedural grounds. The court charged that the state had not observed "due process" in drafting its guidelines, because it had not allowed the public to participate in the guidelines' development.

At the time the guidelines were developed last September, both the state commissioner of health and Education Commissioner Cooperman, the state education chief, felt that the terms of the guidelines were within the scope of their existing powers, explained an education official.

"If it were a child without AIDS who had been denied attendance, there is no question the commissioner would have had the authority" to order a district to admit the child to school, according to Seymour Weiss, director of the state education department's bureau of controversies and disputes. In addition, Mr. Weiss explained, state officials developed the guidelines shortly before the opening of school and "didn't feel we had the time" to go through the extended procedure of formulating state regulations to address the issue—a procedure that would have required a period of public comment before final adoption.

The state education department is appealing the appellate court's decision on the AIDS guidelines to the

state supreme court. At the same time, the state board of education is planning to adopt regulations, in the form of an administrative code, that would require districts to admit most children infected with the AIDS virus to school, except under certain conditions. These regulations would be subject to public review and comment before adoption.

But although some who watch the controversy in New Jersey might label it as a classic case of local districts struggling against state control, one state education department spokesperson recently suggested that state officials are merely trying to put into place a mechanism that will allow children who belong in school to attend school.

At the state board of education meeting in June, according to education department spokesperson Roger Shatzkin, "the Commissioner [of Education, Saul Cooperman] said he believed in the [state's] system of checks and balances [that restrict any one part of government from assuming too much control], but he was totally frustrated by the inability of these kids to go to school in New Jersey."

"The basic point is: if the kids are well enough to go to school—and our best medical evidence is that AIDS is not spread by casual contact—the rest of the [regulatory] apparatus is there to settle conflicts subordinate to that main point," Mr. Shatzkin said. ■

the particular individual in question, and

- instituting health guidelines and sanitary measures designed to minimize the transmission of the disease.

Right to Know v. Right to Confidentiality

A common theme runs through

the caselaw involving employers who have taken adverse actions against employees with communicable diseases other than AIDS because of a fear of injury to the employees' co-workers.

The courts in such cases have held that there must be a "reasonable probability" that employment of the individual would be "hazardous," (32) or a "reasonable probability of substantial harm" (33). Co-workers would have to meet the same burden

of proof as the employer to support a contention that their health is endangered by working with persons who have AIDS. With respect to the issue of an employee's right to know the health status of a co-worker, employees are unlikely to successfully obtain a court order directing their employer to notify them of co-workers with AIDS. The Occupational Safety and Health Act, which applies to some federally assisted public employers, requires employers

to notify workers of "hazards in the workplace" (34). But that provision does not come into play unless it can be shown that there is a real danger posed by the co-worker with AIDS—an unlikely event.

However, in cases where a panel of experts chosen by the school district has ruled that a student with a communicable disease such as AIDS poses a danger to others in the classroom—because of his personal habits or the nature of the disease—school officials would have to notify an employee required to work with the child of the hazard involved.

Student Confidentiality Issues

The issue of "who has the right to know what" is "probably inherently the most difficult question" with respect to the issue of AIDS in the schools, said NSBA forum panelist Kelly Frels, a lawyer who represents the Houston (TX) Independent School District.

Both the Centers for Disease Control (CDC) and the American Academy of Pediatrics (AAP) recommend that school and health officials respect the right to privacy of the student infected with AIDS virus. "The number of personnel aware of the child's condition should be kept to the minimum needed to assure proper care of the child and to detect situations in which the potential for transmission may increase," according to the AAP.

But while doctors at the NSBA AIDS forum stressed that maintaining patient confidentiality is of paramount importance for schools, some educators in attendance questioned the wisdom of keeping the identity of the infected child from school staff. An informed teacher, they argue, can both protect other children from the risk of exposure to the virus and can keep the infected child from potential exposure to other illnesses.

Said Sheila Gutter, a New York City teacher who was part of the NSBA forum's panel: "With all due respect to medical confidentiality, I believe—as will most of my colleagues and the people in this room—that some of that confidentiality has to be revealed to those people directly involved with the child, so that if for instance a

child has a nosebleed in the classroom, or gets ill as they often do and has to regurgitate in the middle of the room, the proper precautions can be taken—not only to help the child, but also to prevent the other children in the room from being exposed to the problem."

In response to those who want to know the infected person's identity in order to protect themselves or others against infection, doctors point to the medical evidence that the risk of transmission of the AIDS virus in school settings is "remote." Others argue that teachers and school staff should be informed in case they have to handle body fluids if, for example, a student with AIDS regurgitates or cuts himself in the classroom. To this doctors respond that teachers and other school staff should follow routine hygienic procedures when handling body fluids for all children, regardless of whether or not the child has AIDS.

In addition to protecting the psychological well-being of the person with AIDS and preventing prejudicial treatment or ostracism of that person, doctors argue that the infected person's privacy must be protected in school simply because no one's interests will be served by releasing his or her identity to more than a few individuals.

A school contemplating disclosure of the identity of an AIDS patient should consult with a lawyer to ensure that its actions do not violate any applicable laws governing the confidentiality of an AIDS student's medical records and/or the privacy of the individual. Schools should be aware that the Family Educational Rights and Privacy Act (FERPA) (35) and U.S. Department of Education regulations concerning disclosure of students records without consent may also apply.

Conclusion

By law, school districts have a duty to provide a safe, healthy environment in which to carry on the educational process. They have a duty to provide handicapped students with a "free, appropriate public education;"

they also have a duty to refrain from arbitrarily terminating or suspending employees.

In addition, school district leaders have a more subtle responsibility, one not enforceable through the legal system: to refrain from exacerbating the public fear of AIDS through ill-considered actions.

The judge in the New York City case, although finding in favor of the central board of education on the legal issues involved, expressed severe misgivings about the manner in which the city's public officials had developed their school policy on AIDS.

In a "commentary" on the case attached to his legal opinion, Judge Hyman acknowledged both that the medical evidence failed to support the community school board's position, and that the board of education and other city officials had not been "arbitrary or capricious" in developing their policy on management of school children with AIDS. Nevertheless, the judge continued, these city officials—because of the way they responded to the situation—bore at least some responsibility for the public controversy that developed:

From the outset, it was clear that the respondents [the New York City Board of Education and other city officials] operated with a notion that they knew what was best and would make all the necessary decisions for everyone's good. Believing this, they acted in an imperious fashion, accepted little by way of inquiry, and no criticism.

Instead of educating and inspiring the confidence and trust of the public, respondents left them frustrated and hostile in the face of such an emotionally charged issue. It is these public officials themselves who predictably, although perhaps unwittingly, let loose the forces of anxiety and fear. Parenthetically, blame is to be borne as well by certain members of the medical community who by their professionally irresponsible and baseless characterizations of this disease as a "plague" only exacerbated the fears and fueled the passions.

The circumstances that led to the lawsuits in Indiana and New York—

and in other districts where similar lawsuits are pending—should provide some guidance to school boards and public health officials. In the New York City case, public education and health officials—because they developed the district's AIDS policy without consulting members of the community—contributed to the anxiety, fear, and anger among parents and schoolchildren in the city. In the Kokomo, Indiana case, a lack of communication and coordination among the various public health officials led to contrary advice being provided to school officials, which in turn exacerbated fears of parents and teachers. Given the public's anxiety about AIDS, and the circumstances surrounding these cases, then, it is no wonder that lawsuits against the school districts emerged.

The answers to all the legal questions raised by the presence of a student or an employee with AIDS in public school districts are by no means yet apparent. Because few cases involving persons with AIDS in

the schools have been decided, districts involved in such suits are to some extent entering uncharted legal waters. The facts involved in the cases that do exist, however, strongly suggest that lawsuits arose in part because of a lack of communication among public officials, and between public officials and the public.

As the number of lawsuits related to persons with AIDS in the schools increases, the legal community will undoubtedly have a better understanding of how the courts will decide such cases. But instead of waiting for legal precedents to be established, school district officials might be better off finding ways to prevent similar lawsuits from occurring in their districts.

Legal and education authorities suggest that school leaders can help prevent the kind of situations that lead to AIDS-related lawsuits by giving the public as much correct information about AIDS as possible, at a time when the public is still receptive to that information. Another important

step is to coordinate statements by public health and education officials about the school district's approach to persons with AIDS in their schools.

One way school district leaders can achieve both of these ends, these experts suggest, is to develop a policy that delineates the district's response to persons with AIDS in the schools—and to develop that policy in the open, by working both with public health officials and with members of the community.

While fashioning a school district policy on management of persons with AIDS may seem difficult, these authorities agree that it is far preferable to enduring the notoriety and divisiveness that often accompany lawsuits against a school district.

The following section explores the development of such school policies, and examines the circumstances surrounding a district where admission of a student with AIDS resulted in community support rather than community outrage. ■

Endnotes

1. The Education for All Handicapped Children Act, 20 U.S.C. § 1400 *et seq.*
2. Section 504 of the Rehabilitation Act, 29 U.S.C. § 794.
3. *District 27 Community School Board v. Board of Education of the City of New York*, Index No. 145940/85 (Sup. Ct. N.Y., Queens County, Feb. 11, 1986).
4. *White v. Western School Corporation*, IP 85-1192C (S.D. Ind., August 23, 1985).
5. *Consolidated Rail Corp. v. Darrone*, 465 U.S. 624 (1984).
6. *Grove City College v. Bell*, 465 U.S. 555 (1984).
7. 772 F.2d 759 (11th Cir. 1985).
8. *Ibid.* at p. 764.
9. *Culpepper v. Reynolds Metals Co.*, 421 F.2d 888, 891 (5th Cir. 1970).
10. *Southeastern Community College v. Davis*, 442 U.S. 397 (1979).
11. *New York State Assn. for Retarded Children, Inc. v. Carey*, 126 F.2d (2d Cir. 1979), affirming 466 F. Supp. 479 (E.D.N.Y., 1978), same case 466 F. Supp. 487 (E.D.N.Y. 1979).
12. 466 F. Supp. at p. 489, n.1.
13. 466 F. Supp. at pp. 499-500 (1979).
14. 3 *Education of the Handicapped Law Reporter* 553:288 (D.Md. 1982).
15. *Ibid.* 15 p. 553:290.
16. *Community High School v. Denz*, 463 N.E.2d 998 (App.Ct. Ill. 1984).
17. *White v. Western School Corp.*, see note 4 above.
18. 104 S.Ct. 3457 (1984).
19. *White v. Western School Corp.*, see note 4 above.
20. *District 27 Community School Board v. Board of Education of the City of New York*, see note 3 above.
21. *E.g.*, Mont. Rev. Code Ann. §40-5-408; Or. Rev. Stat. §433.267; Va. Code § 22.1-270.
22. Valente, *Education Law Public and Private*, 234 (1985).
23. *King-Smith v. Aarn*, 455 F.2d 378 (3rd Cir. 1975); *Board of Trustees v. Porini*, 263 Cal. App.2d 784 (1968).
24. *E.g.*, Alaska Stat. §18.15.145; Cal. Educ. Code § 44839, 49406; Me. Rev. Stat. Ann. tit. 20A, §6551; Mass. Gen. Laws Ann. Ch. 71 §55A; N.M. Stat. Ann. §22-10-10; Pa. Stat. Ann. tit. 24, §12-1209.
25. Conn. Gen. Stat. Ann. §10-207; Mont. Rev. Code Ann. §20-4-106(b); Neb. Rev. Stat. §79-1247.06; Nev. Rev. Stat. §391.312(f); Utah Code Ann. §53-2-25.
26. *E.g.*, Ark. Stat. Ann. §80-1210; Me. Rev. Stat. Ann. tit. 20A, §6551.
27. *E.g.*, Cal. Educ. Code §49406; W.Va. Code §16-3-4a.
28. *New Jersey v. T.L.O.*, 105 S.Ct. 733 (1985).
29. *Baum v. Reed College*, 401 P.2d, 294 (Or. 1965).
30. *See, e.g.*, *Earle v. Kuklo*, 98 A.2d 107 (N.J. Super. A.D., 1953); *Gilbert v. Hoffman*, 23 N.W. 632 (1885); *Kleigel v. Aitken*, 69 N.W. 67 (1896).
31. *Bang v. Independent School District No. 27*, 225 N.W. 449 (1929).
32. *B&O R.R. Co. v. Bowen*, 60 Md. App. 299 (1984).
33. *Mantolite v. Bolger*, 767 F.2d 1416 (9th Cir. 1985).
34. The Occupational Safety and Health Act, 29 U.S.C. § 254.
35. Family Educational Rights and Privacy Act (Buckley Amendment, 20 U.S.C. § 1232g.

AIDS and School Policy Development

Participants in the NSBA forum on AIDS, and other health care, legal and education professionals, all have emphasized the need for school districts to develop policies concerning management of students and employees with AIDS. Development of such policies, experts suggest, not only will alleviate anxiety in schools with no cases of AIDS, but it can also prevent public hysteria if a student or staff member is identified as having AIDS.

But few educators would suggest that development of a policy on management of persons with AIDS will be an easy task for school district leaders. In the first place, the medical complexities of AIDS and its devastating consequences may leave some school board members feeling they lack the expertise to design a policy concerning the disease.

Second, the fact that AIDS is such an emotional issue for many communities may make school district leaders reluctant to consider AIDS policy development until they are faced with an student or employee who has AIDS—which experts agree is an inopportune time to be designing policies.

Finally, some school officials may believe that designing policies for responding to persons with AIDS is not their responsibility. Because AIDS is a health issue, some may argue, policy development should be handled by either the state or the local health departments.

But, although AIDS may be a relatively new disease, the development of policies concerning management of persons with communicable diseases is not a new issue for schools (see box, page 39).

Policy Development for AIDS and Other Communicable Diseases

Some districts have developed extensive communicable disease policies with strategies for responding to a long list of communicable illnesses, including chicken pox, measles, influenza, whooping cough, and impetigo. Other districts prefer to write brief general policies that summarize

in a paragraph or two the appropriate response of school officials. The South Carolina School Boards Association, for example, has developed one such sample communicable disease policy which it suggests is sufficiently broad to encompass cases of AIDS in the schools. It reads:

The school board reserves the right to remove or exclude any child whose physical condition would interfere with his or her ability to learn or would expose other students to infection. When a student has been prohibited from school attendance as provided above, the school board may require a satisfactory certificate from one or more licensed physicians that such attendance is no longer a risk to the student or to others attending school.

Notification of other students and staff of the existence of a communicable disease shall be accomplished in accordance with regulations and guidelines promulgated by the Department of Health and Environmental Control.

School officials thus can review their existing communicable disease policies for assistance in developing policies for management of persons with AIDS in their schools. In doing so, however, school district leaders should keep in mind three important differences between AIDS and many other communicable diseases:

- The virus that causes AIDS is not transmitted by casual contact, such as would occur in schools; that is, it is much more difficult to catch than disease agents that cause many other communicable diseases;
- AIDS is a disease with no cure, from which no one has yet recovered; therefore, the consequences of developing AIDS are much more grave than those associated with many other communicable diseases that can affect persons in schools;
- People often forget the first difference and remember the second; therefore, public reaction to the presence of a person with AIDS in the schools can reach the level of hysteria.

In recent years, only the skin condition herpes, which causes

Communicable Diseases and the Schools

The issue of communicable diseases is hardly a new one for school officials. Nearly all school districts have some form of policy on children with communicable diseases, including keeping students with highly contagious diseases out of school. But the development of vaccination and inoculation procedures against many once-common childhood illnesses has sharply reduced the number of school-age children who suffer from these illnesses. In addition, increased medical understanding of the nature of some other diseases has altered school policies for treating students with those diseases.

Less than 50 years ago, notes a recent report on AIDS and the schools from the Education Commission of the States, "children with chronic illness were unable to attend school or receive instructional services. Diseases, such as polio and smallpox, were so contagious that children with these diseases, and in some cases, children who were exposed to these illnesses were excluded from school. In years prior to vaccinations and inoculation for disease, the quarantine was to protect the public health."

A vaccine against the poliomyelitis virus, which causes polio, was introduced in 1954. Between that time and 1984, according to the Alliance

for School Health in Fair Oaks, California, reported cases of polio in the United States dropped from 38,475 to 8.

Vaccines against measles, rubella (also called German measles), and pertussis (whooping cough) were introduced in 1963, 1969, and 1966, respectively. Between the time of vaccine introduction and 1984, the number of measles cases reported dropped from "more than" 500,000 to 2,534; the number of rubella cases dropped from 57,686 to 752; and the number of pertussis cases dropped from 7,717 to 2,276, according to the Alliance for School Health.

A vaccine for hepatitis B was introduced in 1982. The number of reported cases for this disease has risen, however—from 22,177 to 26,115—apparently because of "lack of use of vaccine by high risk groups," the Alliance says in a recent booklet, *Infectious Diseases Update*.

Immunization programs—which require that children show adequate proof of immunity or vaccination against certain childhood diseases before being admitted to school—are one way to curtail the spread of disease in schools.

"By preventing costly outbreaks, reducing incidence, mortality and disability from preventable disease, we can with some degree of confidence

guarantee a lifetime of protection against measles, mumps, rubella, polio, diphtheria, pertussis (whooping cough) and tetanus," notes an article in the May 1986 *New York State School Boards Association Journal* on communicable disease control and the role of school officials, prepared by officials from the New York State Health Department. (Emphasis NYSSBA's)

"With the continued support and diligent daily efforts of the educational system we will maintain the present high levels of protective immunity against childhood diseases."

But immunization programs are not the only way school officials control the spread of disease. "Even today," notes the Education Commission of the States in its report on AIDS, "46 states excuse from compulsory school attendance students with chronic illness."

The exclusion of certain students from compulsory attendance laws, however, does not mean that states can allow these students to go without an education. "Rather, the state is obligated to provide an education in an alternative setting that meets the needs of the child," the ECS notes. The issue for school officials and policymakers, the ECS says, thus becomes not "whether to educate" these children, but "how to educate them." ■

"unpleasant" recurrent skin lesions, has aroused anything like the controversy AIDS has generated in some school districts in this country.

Although herpes is an incurable disease, unlike AIDS, it is not fatal except to some newborn infants. Herpes lesions may not be life-threatening, but they are unsightly, and the virus that causes it can be spread by contact with an uncovered lesion.

The presence of a three-year-old child with herpes led to court actions by teachers and student boycotts of classes in two school districts in 1984 and 1985. In both cases the infected

children were allowed to return to school only after school officials agreed to have them checked each day to make sure active lesions were covered.

In one district—the Anne Arundel (MD) Public Schools—the checking procedure was part of policy the district developed for admitting preschool children with herpes to school. In the Council Bluffs (IA) school district, the evaluation procedure was part of a limited court order developed by a federal judge in response to a suit brought by teachers. That order expired in the fall of 1985, and the Council Bluffs

(IA) school district officials have not developed a separate policy for treating students with herpes. Instead, according to one Council Bluffs school official, cases of herpes are handled according to the terms of the school's existing policy for management of students with communicable diseases.

"The only policy we had and the only policy we have now is that students who present a significant health risk to others around them are to be excluded from school," said Ted Stilwell, executive director of educational services for the Council Bluffs schools.

This issue—whether or not to develop a specific policy for a single disease—also applies to the AIDS policy debate.

As with AIDS, those children with herpes who receive public attention as a result of their affliction represent a small percentage of those persons in schools who are infected with the virus that causes herpes, education and health authorities have pointed out. The Alliance for School Health has estimated that, at any given time, between two to ten percent of the general population is capable of transmitting the virus that causes herpes.

For that reason, Mr. Stilwill suggested, school officials saw no point in developing a separate policy to address persons with herpes in their schools.

School leaders in each district said the concerns of parents and staff about the infected children arose primarily from their lack of information about herpes and how it is transmitted.

Although AIDS and herpes are very different illnesses, they have two common characteristics: each has only recently begun to afflict children, and each elicits a high level of public distaste and fear.

Because these are diseases that most school districts have not yet had to deal with, a school district's existing communicable disease policies may not cover the management in schools of person infected with herpes or AIDS. And because they can cause such a violent community reaction, school officials may not want to risk developing policy to address them, for fear of fomenting controversy.

But although a disease such as AIDS may be an issue that many district officials would rather not face, some districts—as we have seen—have already had cases of students or employees with AIDS, while other districts have developed policies concerning management of persons with AIDS. And while such a task may seem difficult, school district leaders should be aware that development of a policy to address AIDS is not an effort they should undertake alone. Instead they can and

should turn for assistance to local public health officials, and to state education and health authorities—many of whom have already launched campaigns to help school districts in this area.

State Assistance in Local Policy Development

Recent state efforts to assist districts coping with the spectre of AIDS in their schools have taken a variety of forms, including intensive public education programs in communities and inservice workshops for school officials.

In June, for example, officials from the Michigan state education and health departments held three regional workshops across the state for officials from local school districts and local health departments. The goal of the workshops was to show local school officials that they should be working on issues involving AIDS in the schools in tandem with local health departments.

“Our concept was to get the districts to perceive the concern [about AIDS] as one they didn't have to deal with alone, but that they have the expertise of local health departments to help,” said Barbara Hower, a health education consultant for the state's education department.

Such state AIDS education efforts have given state officials a chance to see how many districts are working to develop policies that address AIDS.

At the Michigan conference, state officials “strongly emphasized” the need for districts to develop policies and to be prepared “before something happens,” according to Ms. Hower. In querying district representatives at the conference, however, state officials found the number of districts that had actually developed policies was “very small,” and included primarily the larger communities. “Far more were discussing policy development,” she said.

In the recent reissuance of its administrative guidelines (first released

in March, 1985), the Connecticut state education department included a sample policy addressing AIDS, herpes, and cytomegalovirus in schools, because so many district officials had called the state for assistance with policy development, according to Elaine Brainerd, a consultant for school health services with the state's education department and the chairman of the task force that drafted the administrative guidelines.

“Everyone is studying how to write policy before they have infected students,” she said. Most districts in the state have put AIDS policy development “on their agenda; they have started discussing or drafting policies.”

State AIDS education efforts may be having an effect; more than one state official has suggested that members of the general public are more knowledgeable about and less fearful of AIDS than they were a year ago.

“I have noticed in doing presentations that the sophistication of questions has increased,” said Cheryl Haug-Simons, the project director for health and human development in the Massachusetts education department and a coordinator of the state's AIDS education efforts.

One education policy analyst has suggested that such an increased awareness of the concerns raised by AIDS in the schools may allow many district leaders and communities to respond to the issue more calmly than they perhaps would have a year ago, a factor which may assist in policy development efforts.

“Things have settled down,” said Grace Belsches-Simons, a senior attorney with the Law and Education Center of the Education Commission of the States. “[And] districts make better policy when things have settled [rather] than in the throes of emotion.”

State Laws and Guidelines

In addition to education efforts, more than 20 states also have attempted to assist school districts by developing recommendations for management of persons with AIDS.

In some states, these recommendations are informal guidelines intended as models on which districts can build their own policies. In other states, these recommendations function as regulations that districts are bound to follow. District legal staff should determine the nature of any existing state guidelines related to this issue before beginning development of a district AIDS policy.

States that have developed recommendations for school management of persons infected with the AIDS virus tend to favor review of individuals on a case-by-case basis, with the majority of states suggesting that most infected children be educated in a classroom setting.

Many of the state guidelines were developed either by state health departments, or by state health departments working in conjunction with the state education department. Several of the state guidelines use as their model the Centers for Disease Control recommendations for education of children infected with the AIDS virus.

In addition to state AIDS guidelines, most states have communicable disease laws and state education regulations that govern how school districts may respond to persons with AIDS. State laws concerning public employees, including those protecting against discrimination and unreasonable firing, may also govern a district's treatment of employees with AIDS.

Districts should be aware that state statutes that address some issues—for example, those protecting handicapped students or employees—may be much more stringent in some states than federal laws pertaining to the same issue. Therefore, a legal review of pertinent state laws—from education and health laws to public employee laws—should be the starting point for any district AIDS policy development effort.

State Guidelines, Local Control

In the short time they have been in existence, state recommendations on management of persons with AIDS in

schools have elicited a variety of responses from school districts around the country.

For the most part, guidelines developed by states function as their name suggests: they are frameworks for school districts to use in developing their own policies.

In Michigan, for example, "Some districts look to the state for guidance, and some do not," said Ms. Hower of the Michigan education department, which released its guidelines in April.

But although many school districts turn to the state for guidance concerning management of persons with AIDS, other districts, at the same time, do not wish to be bound by state policies if they disagree with them.

"It is imperative that the state take the leadership role in these matters," school district officials in Montgomery County (MD) Public Schools wrote to officials in the state health department in commenting last October on the state's proposed guidelines for management of persons infected with the AIDS virus.

"This [leadership role]," the letter continued, "includes the medical, educational, legislative, and administrative branches of state government's provision of all possible assistance to local education agencies in dealing with this most serious public health issue. We should not be placed in such precarious positions that in lieu of appropriate state leadership, we find each jurisdiction 'reinventing the wheel.'"

The Montgomery County school officials' final recommendation concerning the state guidelines, however, was to "urge prompt adoption of state guidelines/regulations on AIDS/ARC/HTLV-III which allow local education agencies options for excluding HTLV-III infected persons"—a situation which would allow for a blend of state guidance and local control of the situation at the district level.

Depending on the state, however, a school district's right to develop policies that are at odds with the

state's position on school management of persons infected with the AIDS virus may be limited, some state education officials have suggested.

Massachusetts, for example, introduced a state policy governing school attendance by children with AIDS or with AIDS virus infection last September. The policy states that "all children diagnosed as having AIDS or with clinical evidence of infection with the AIDS-associated virus (HTLV-III) and receiving regular medical attention are able to attend regular classes," except under certain conditions such as exhibiting "inappropriate behavior," having open skin lesions, or being too sick to attend school.

Under the terms of the policy, "districts can't exclude kids except for the reasons outlined in the policy," according to Ms. Haug-Simons of the state's education department.

If a district were to attempt to exclude a student for any other reason, she said, education department legal officials and officials from the department's regional office would contact the district and explain the state policy.

Health and education department personnel would visit the school, if necessary, to provide further information on the disease, she said. If the district still refused to allow the child to attend school, however, "It ultimately would go to court."

Ms. Haug-Simons stressed that Massachusetts has not been faced with such a situation, perhaps because state health and education officials have made a point of visiting those districts where school officials or members of the community have questions on admitting students with AIDS to schools. She noted that the state epidemiologist, Dr. George Grady, has himself made more than 50 visits to districts throughout the state to answer questions about AIDS.

Benefits of State/Local Cooperation

Decisions concerning policy development for the management of persons with AIDS in the schools are

One District's Experience with AIDS Policy Development

The experience of school district officials in the Montgomery County (MD) Public Schools, in the fall of 1985 reflects several of the issues officials in other districts may face in developing a policy for management of persons with AIDS.

At the beginning of the fall 1985 semester, according to Edward Masood, the director of the department of driver education, health, physical education, and athletics for the suburban Washington, D.C. school district, district officials were already developing their own policy statement on AIDS when they had to confront two issues related to AIDS in the schools: proposed state AIDS guidelines, and concern from the public over the deaths of two district teachers from the disease.

In the last week of September, 1985, the state education department asked superintendents of schools throughout the state to review and comment, by mid-October, on proposed guidelines developed by the state health department for management of persons with AIDS in the schools.

The proposed state guidelines recommended that "decisions regarding the type of educational setting for HTLV-III infected children should be based on the behavior, neurologic development and physical condition of the child." Further recommended was the use of a "team" consisting of a physician, the child's parent or guardian, and school and local health department officials.

At the time, however, Montgomery County school officials were not in full agreement with the state suggestions. In a letter to the state health department, Montgomery County school officials said they wanted to "retain the prerogative to be more restrictive than the proposed [state] guideline should we choose to do so."

While developing their response to state officials, school district leaders found themselves facing another kind of pressure related to AIDS. On October 1, 1985, a television reporter

asked school officials to confirm that one of the district's teachers had died of AIDS the previous June.

In their statement to reporters concerning the teachers' deaths, school officials noted that they currently were developing a policy on AIDS "to ensure the safety and health of all . . . students and staff." The statement also noted that the state was developing AIDS guidelines for schools as well.

School leaders have suggested that the district was subject to increased publicity because the story about the teachers' deaths aired on one local television station on October 2, 1985, the day after the actor Rock Hudson died of AIDS. But whatever its cause, the publicity meant that county school officials were "hard pressed to come up with something" in the way of guidance on management of persons with AIDS. Mr. Masood said, adding: "We couldn't wait for the state."

In addition to facing separate pressure from the public and from the state, county school officials themselves originally were far from united in their approach to developing the policy on AIDS. Mr. Masood recalled that initially he believed AIDS to be "a communicable disease situation," and as such, "It should not be handled by [school boards]." Instead he felt that "it should be handled by local health departments, who have the only jurisdiction concerning communicable diseases in every community in this country."

School board members and district officials worked closely with the local health department to develop the guidelines, eventually reaching a "very amicable agreement," he said. They also reviewed guidelines from several other states and local school districts, and considered suggestions from officials with the state department of health, medical experts at the National Institutes of Health (which is located in Montgomery

County), and from Dr. Jaffe (who graduated from a Montgomery County high school) of the Centers for Disease Control (CDC). And although officials may have disagreed in closed sessions, he noted, they were careful to present a united front in public statements on the issue.

The board adopted its policy in January of 1986, a few weeks after the state released its guidelines. The Montgomery County policy that resulted is "non-exclusionary in nature" and addresses both students and employees who have been diagnosed with AIDS, calling for individual evaluation to see if the infected person should remain in the school setting, according to Mr. Masood. It agrees both with guidelines issued by the county health department and with the state guidelines; all guidelines are based on those issued by the CDC in August of 1985.

District officials also have planned an "extensive educational program" about AIDS and the district's response to disease, aimed at staff, students, and the Montgomery County community.

The district has not yet had to use its policy on management of teachers and students with AIDS, because no other teachers and no students have been diagnosed with AIDS. Now that the effort is completed, however, Mr. Masood said he supports the idea of school involvement in AIDS policy development.

"[AIDS] is an issue that needs to be addressed in the open," he suggested. "There aren't too many things that come along in life that are absolutely 100 percent fatal. [It] scares the hell out of people."

The policy and education efforts the district has instituted, Masood believes, will go a long way toward allaying fears if a student or employee is diagnosed with AIDS. "I think we'll be able to beat the hysteria," he said. ■

most successful when there is joint effort between state and local officials, according to those who have studied the issue. In some states, district officials may feel that the nature of the state guidelines makes it unnecessary for them to develop their own district policy. Many local districts, however, may find that development of a local policy—one which is not in conflict with state policy or laws—can help them in two ways.

First, the activity of developing a local policy is a good opportunity for school district leaders to confront and study the issue of AIDS in the schools. It is vital for school leaders to have knowledge about the disease, because such knowledge can help them to combat the fear of AIDS that results from lack of knowledge. Second, school district leaders—even in states where districts are bound by state AIDS recommendations—may feel more comfortable enforcing a policy they themselves have reviewed and approved, should they be faced with a student or an employee who has been diagnosed with AIDS.

Development of Policy at the District Level

Those districts faced with the task of developing a policy for management of persons with AIDS in their schools can be guided by several models, including recommendations from the Centers for Disease Control and the American Academy of Pediatrics, guidelines developed by several states, and guidelines from other local districts.

But as district officials study other policies for assistance in developing their own, they should be mindful of a strong caution from Ms. Brainerd of the Connecticut education department.

"I don't think that anyone can take the Connecticut policy [or any other policy] and just adopt it," she said. Instead, she suggested, officials must take part in a "dialogue" as they develop a policy for their own district—a dialogue with public health officials, school staff, parents, students, and other concerned com-

munity groups. (See "How to Build a Policy," page 44).

"You've got to have that dialogue and let people grow and have that evolution of understanding before you have acceptance," she said.

Those who fashion the policy "need to address all the concerns" of these various groups, according to Ms. Brainerd. The task may be difficult, but it is absolutely necessary for the success of the policy, she emphasized.

If school district leaders fail to address all these concerns, the policy "isn't going to work," she said simply. "The first time you have to use it, it will fall apart."

Elements of Policies

State guidelines or policies from other districts, then, can serve as a framework for school district leaders, upon which they can build their own policy to address management of persons with AIDS in the schools. As we have seen, such a policy need not be specific to AIDS; rather, it can be an expansion of the district's existing policy on communicable diseases. But no matter how they may differ in language, many of these policies have several elements in common:

- They define the disease or diseases under consideration and state the district's response to infected persons;
- They name the medical and other personnel charged with evaluating the infected person;
- They describe the administrative process by which infected individuals are removed from, readmitted to, or remain in the school;
- They address the need for alternative arrangements for students or employees who are removed from the school;
- They consider the need to respect the infected individual's right to privacy, as far as is possible; and
- They outline procedures for appropriate hygienic measures to protect the spread of any infection in the school.

Some district policies address only students with AIDS; those that address both students and employees with AIDS may respond to each group differently. A review of these elements, as they appear in policies

for management of students with AIDS, and in policies for management of employees with AIDS, may assist district officials with their own AIDS policy development.

Elements of District Policies for Students with AIDS

Definition of the Disease under Consideration and the District's Response to Infected Persons.

Some districts have developed policies that respond specifically to students with AIDS, while other districts have revised their general communicable disease policies so that they are appropriate for use if a student is infected with the AIDS virus.

Still other districts have developed policies that include AIDS with certain other illnesses that health officials suggest may be similar in terms of their treatment, care, and level of infection.

The policy for the Topeka, Kansas, public schools, for example, addresses both AIDS and hepatitis B. The policy for the Parkway school district in Chesterfield, Missouri, includes AIDS among several other "chronic communicable, contagious and/or infectious diseases," including cytomegalovirus, herpes simplex virus, and hepatitis B. These diseases are defined as distinct from "common childhood diseases/acute or short-term communicable diseases" such as chicken pox, impetigo, strep throat, and scarlet fever.

Both policies, like many such district policies, favor evaluation of infected students for fitness to attend school on a "case-by-case" basis. The Topeka policy notes that certain students with either AIDS or hepatitis B, such as those who lack control of body secretions, display behavior such as biting or vomiting, or have uncoverable oozing lesions, are to be educated separately.

Identification of the Medical and other Personnel Charged with Evaluating the Infected Student.

Several district AIDS policies specify those persons who have responsibility

How to Build a Policy

In an editorial last winter in *School Board News*, Thomas A. Shannon, the NSBA's executive director, offered his own set of suggestions for school boards struggling to develop policies that address persons with AIDS in the schools.

Like Dr. Myers, Mr. Shannon strongly urged that school boards maintain their "initiative of leadership" on this issue, because to do otherwise would be to allow a variety of special interest groups associated with the issue to attempt to seize control of public opinion.

"The political implications of the AIDS problem are substantial," Mr. Shannon writes. "If school boards and superintendents let medical and legal uncertainties paralyze them into no action—or deferrals of action—they will forfeit the initiative of leadership that is so vital in moving a district forward on a constructive course."

The result of such abdication of responsibility, Mr. Shannon suggests, would be a public policy on AIDS dictated by "ignorance and political hysteria"—which public school officials "cannot permit."

Mr. Shannon notes, however, that allowing special interest groups to seize control of development of public policy on an issue is not the same thing as "including them in the process" of policy development established by the school board and the superintendent. The former, he suggests, is dangerous; the latter, a natural part of school board policy development.

With respect to development of policies for persons infected with HTLV-III in the schools, Mr. Shannon offers a five-step program, as follows.

Step 1. "Identify the people who are immediately concerned with AIDS." Students—both those afflicted and those who are healthy—are part of this group, along with local public health officials and medical experts in pediatric AIDS, parents, school administrators, teachers and other staff—both those with AIDS and those free from infection.

In this first step, board members must ask such questions as: "How can the rights and interests of all of these people be balanced within an overall public policy framework?"

Step 2. "Identify the people concerned tangentially with AIDS." These people would include "anyone with a particular or general interest in the health issue—such as legislators, the general public, the media, and so forth," Mr. Shannon says. Here, board members must ask themselves: "What are these persons' specific interests, and how should they be addressed?"

Step 3. "Identify the overall public policy questions within the district that transcend the people immediately and tangentially concerned with AIDS."

Step 4. "Set up a process that will involve the people immediately concerned with the exploration of the problem, the identification of the issues and the drafting of a school

board policy that will even-handedly balance all of the rights and interests identified."

Help at this point can come from legal and medical advisors, as well as from a close review of the CDC guidelines. Mr. Shannon notes that a panel of legal and medical experts at an American Bar Association Education Law Committee meeting last fall concluded that "schools, universities and colleges should mold their policies on the foundation set forth in the CDC guidelines."

Board members must make certain here that "the school board, ultimately, adopts the policy—after holding hearings on it," Mr. Shannon says. And, he continues, "in my judgment, [this policy] should be part of a broader district policy on communicable disease—so as not to focus undue attention on AIDS alone."

Step 5. Design an educational program—"not just about AIDS itself but also about the policy the school board is developing, or has developed—to deal with the practical problem of AIDS."

This step allows the board to "demystify AIDS to the extent possible and, at the same time, show that the school board and superintendent are in clear command of the situation—at least to the extent that anybody can be," Mr. Shannon concludes. ■

for determining whether a student infected with the AIDS virus can attend school. Often the decision is made by a team of persons, which can include the student's physician, a local health officer, school administrators, a teacher who works closely with the student, and a representative for the student such as a parent or guardian.

The Fargo, North Dakota, school district's policy on children with chronic communicable diseases, for example, states that such a determina-

tion is made by a team which includes: the building principal, the child's primary teacher, the child's parents or other representative, a representative of the local health department, an infectious disease consultant, the reporting physician, and the school district's director of special services.

Such teams provide a balance of opinions, and ensure that no single person has the sole power to determine in what manner an infected student will be educated.

Description of the Administrative Process by which Infected Students are Removed from, Readmitted to, or Remain in the School.

Some district policies describe in detail the steps involved in deciding on the appropriate educational setting for students infected with the AIDS virus, and notifying the student and his or her parent or guardian of the decision. The policy of the Parkway school district in Chesterfield, Missouri, for instance, gives the

district ten days following the report of an infected child to select individuals who will serve on the evaluation team, and gives that team another ten days to reach its determination, which is to be communicated in writing to the student, the parents or guardian, the building principal, and the superintendent. The student or parent then has five days to appeal the district's decision.

Designation of one district official as an "AIDS contact person" may make handling issues related to AIDS less difficult for school districts, Dade County (FL) school district leaders suggest. In an effort to reduce confusion, the Dade County school district has given one of its administrators the responsibility of responding first to any question related to AIDS—in students or employees—in the district. Other school officials may then be called in as needed to address that issue. This administrative procedure, district officials say, allows for a uniform response to the issues that AIDS raises in the district.

Determination of Educational Arrangements for Students with AIDS

All school districts are governed by state and federal education laws that require them to provide a free public education to school-age children residing within their jurisdictions. As we have seen, the controversy surrounding school students with AIDS centers on where to provide that education.

The few districts nationwide who have already faced the issue of students with AIDS in their schools have for the most part either chosen to admit them, with a set of mechanisms in place to monitor their condition, or to educate them at home.

The Dade County (FL) Public Schools, however, has devised a plan which is neither regular classroom instruction nor home study: a set of triplets with AIDS attend school, but in a classroom separate from other children, where they are instructed by teachers who receive periodic health examinations and are guaranteed anonymity.

Officials who choose to admit students with AIDS to study in their

classrooms say they do so because they are convinced that the health risks to other students are minimal; that student will benefit from being in school; and that he or she is well enough to attend school.

In some districts where students with AIDS have been barred from school, officials have said they did so because of their understanding that AIDS is a communicable disease and that, in their districts, children with communicable diseases are not educated in school with other children.

In other districts, officials have said they simply did not have enough information about the way the disease is spread to recommend admitting the child.

In some districts' AIDS policies, educational arrangements for the infected child are determined as part of the "case-by-case" team review process. If the child is found to be fit to attend school with other students, then his or her education continues there. If the team evaluation finds the child not able to be in a classroom, the team determines the best educational setting for education for that child. Most policies favor periodic re-evaluation of the child to see if the educational setting remains appropriate.

In districts where officials have decided that all children infected with the AIDS virus should be educated in a non-classroom setting, policies may be similar to that of the San Diego (CA) school district, which states in part: "the San Diego Unified School District is responsible for providing an education for all of the students of the district pursuant to the requirements of the Education Code and in the best possible educational setting for all concerned. When the district is informed that a student has been diagnosed by his or her physician [as] having Acquired Immunodeficiency Syndrome, the student shall be provided an appropriate education in a non-classroom setting."

Maintaining Respect for the Infected Student's Right to Privacy, as Far as Is Possible.

Protecting the identity of a student infected with the AIDS virus may

seem like a difficult task for school district officials. On the one hand, medical officials suggest, a student will invariably feel more comfortable if as few persons as possible know about his or her affliction. On the other hand, school personnel who work closely with the child may want to be informed of the child's condition.

District policies that address the issue of confidentiality often advocate confining information about the infected child to a limited group of school personnel, who may be defined as those person with an "absolute need to know." Such persons generally include those teachers who work directly and closely with the child.

A Historical Precedent

The current lack of consensus concerning policy development for staff and students with AIDS is not without precedent in the history of school district communicable disease policy development. More than 20 years ago, the guide *School Health Services*, published jointly by the American Medical Association and the National Education Association, noted that although many districts had similar policies governing exclusion of children infected with highly contagious diseases from school, few shared policies governing readmission of those children to school.

"Readmission procedures are probably the least uniform part of communicable disease control in schools," the AMA/NEA book stated. "Some state laws specify the procedure by which a child can be readmitted. In some areas, special regulations are passed by the education department, sometimes a local health department is made responsible, and sometimes the doctor in charge of the case. In many areas, the child simply returns to school." ■

Development of Procedures for Appropriate Hygienic Measures to Prevent the Spread of any Infections in the School.

Those medical authorities who favor admission of most children infected with the AIDS virus to school argue that school personnel should have in place standard hygienic measures to prevent the spread of any infection, whether or not a child with AIDS is present in the school. These measures, the medical experts say, will then be sufficient to prevent the spread of the AIDS virus if infected children attend school.

Some school districts have developed policies separate from AIDS policies that describe such hygienic measures.

The Hamden, Connecticut, school district, for example, has developed a three-page set of "Regulations for Handling Body Fluids in School," intended to reduce the risks of transmission of communicable diseases in district schools. The regulations advise avoiding direct skin contact with the body fluids of others when possible, including wearing gloves when such contact is anticipated; following proper cleaning techniques when unanticipated skin contact with body fluids occurs; and removal of spilled body fluids from the school environment by proper cleaning techniques, including disinfection of the contaminated surface with a bleach solution or germicide.

Other districts incorporate advice about proper hygienic measures into their AIDS policies. The Parkway policy, which applies to students infected with the AIDS virus, cytomegalovirus, or the herpes simplex virus, notes that "caretakers [of the infected children] will practice good hygienic techniques, including a thorough handwashing after exposure to an infected student's secretions and before coming in contact with another student." Cleanliness and avoidance of an infected student's secretions, the policy suggests, "are the best prevention."

Elements of District Policies for Employees with AIDS

Many school districts' communicable disease policies

—including those AIDS policies that exist—concentrate on students with such diseases. Statistics on AIDS cases from the Centers for Disease Control, however, show that school districts are much more likely to encounter teachers and other staff persons—rather than students—infected with the AIDS virus. As we have seen, out of the nearly 22,000 cases of AIDS recorded in this country by June, 1986, only 400—or less than 2 percent—involved children 19 years of age or younger.

Policies that address employees with AIDS may be similar in several respects to policies for students. Of those policies that currently exist for school employees with AIDS, some provide for a periodic team review of the employee to determine his or her fitness for work, with each case handled individually, as with similar procedures for evaluating students with AIDS.

As with students, many policies concerning employees with AIDS indicate that the infected employee's right to medical confidentiality is to be respected. Some districts require that employees who have been diagnosed with AIDS tell one particular administrator with whom they work, who then becomes part of the employee's periodic review team.

Unlike those policies designed for students, however, policies for employees with AIDS can touch on issues such as:

- staff health;
- determination of an alternative staff assignment or transfer, if necessary;
- health insurance and leaves of absence;
- disability insurance or other compensation provided if the employee is removed from the job;
- other fringe benefits.

In developing a policy for employees with AIDS that addresses these issues, school district leaders should be careful that such policies not conflict with any federal or state laws governing employer treatment of public employees, with local collective bargaining agreements, or with already existing district policies.

School Districts as Employers

Although school districts differ from employers in the private sector in some respects, they nonetheless share certain concerns. A recent issue of the publication *Boardroom Reports* offers some advice for developing a company AIDS policy that school district leaders may find useful.

The issues that AIDS in employees can raise for employers, *Boardroom Reports* notes, include:

- Antidiscrimination suits caused by firing or failing to hire someone who either has AIDS or has tested positive for the AIDS virus antibody;
- Defamation suits from employees who have been wrongly identified as having AIDS. (One high school teacher in Massachusetts, who was being treated for a blood disorder related to mononucleosis, told *The New York Times* last February that school officials ordered him to take a medical leave and then resign after rumors started circulating in the school system that he had AIDS. He has filed a claim against the school district with the state's Commission Against Discrimination.);
- Disability claims that "don't fit the pattern for other diseases"; and
- In some situations, civil rights penalties when an employer prevents an employee with AIDS from working.

School district leaders, in some cases, may find that existing school board policies that address these employee issues are sufficiently broad to cover cases of employees with AIDS. The *Boardroom Reports* article suggests that creating a special AIDS policy may create "a paranoia among employees," and could cause them to ask such questions as "What would my company do for me if I got lung cancer?"

Instead, the article in *Boardroom Reports* urges employers to "develop a health policy that includes all catastrophic illnesses, not just AIDS." The objectives of such a policy are "to stay out of legal trouble, keep benefits costs from rising and maintain morale in the workplace."

In the Dade County (FL) Public Schools, where ten employees have died of AIDS between 1980 and 1985, members of a task force reviewing the issue recommended against development of a separate policy for employees with AIDS. Instead, the task force suggested that current school fitness evaluation procedures based on school board rules and labor contract agreements should be the basis for making decisions on the mental and physical fitness to work of employees with AIDS.

As a result, cases of employees with AIDS are to be handled on an individual basis, through the school district's Office of Professional Standards, according to Dade County school district officials. After the status of the employee is determined by the fitness procedures, a determination is made about the employee's return to the original job or re-assignment to an isolated work environment.

A Formal Board Policy or a Board Position?

Despite a belief by many education policy analysts that school boards should develop a policy that addresses students and employees with AIDS, opinion on the subject is far from united in the approach one should take on this issue.

For example, the Dade County Board of Education chose to adopt the recommendations of the task force on employees with AIDS as a board position rather than a policy—because the board determined that it already had procedures in place that covered cases of employees with AIDS.

One school district official in California has suggested that a formal board policy on AIDS for districts "is probably inappropriate," for several reasons.

In a September 10, 1985 letter to school districts in the county, Stuart E. Gothold, superintendent of the Los Angeles County Office of Education, suggests that school districts should "consider their positions" with respect to educating children with AIDS. However, he continued, developing any kind of 'blanket policy' that would govern decisions about AIDS cases may be unwise, both because knowledge about the

disease is constantly increasing and because the disease may affect different students, their schools and their families in very different ways.

"[I]t may be wise for district staff and local boards of education to consider their positions" on providing educational services to children who are afflicted with AIDS, Mr. Gothold wrote. "This does not necessarily mean developing a formal board policy. In fact, a formal policy on the AIDS situation is probably inappropriate because—in terms of policy—AIDS should not be treated differently from any other communicable disease."

"It is the position of the Office of Education that each case involving the question of how to provide educational programs to victims of AIDS should be reviewed individually and on its own merits with no 'blanket policy' guiding the decision," Mr. Gothold continued.

The experience of the first school district in this country to successfully admit a student with AIDS to class gives some support to Mr. Gothold's theory. Officials at the Joseph Case Junior High School in Swansea, Massachusetts had no policy for management of students with AIDS in September 1985, when they realized that one of their students had developed AIDS and was seeking to attend school. They were nonetheless able to avert a public uproar when they decided to admit the student, by means of careful planning and with the help of a predominantly sympathetic community. A review of events in Swansea in the fall of 1985 may prove instructive for all school district leaders—whether they are planning to develop a district policy or a less formal district position with respect to students and employees with AIDS.

Students with AIDS: How to Prevail over Fear

School officials in Swansea, a small town near Providence, Rhode Island, learned one week before school opened in the fall of 1985 that one of

their students, a hemophiliac, had been afflicted with AIDS, according to school principal Harold G. Devine, Jr.

Writing in the May 1986 *Executive Educator*, Mr. Devine said that school officials recognized that, before making any decisions about admitting the student, "we needed more information." Mr. Devine and superintendent John McCarthy contacted both the state departments of education and public health, as well as the Centers for Disease Control, "for guidelines that would help us decide on the proper course of action."

At that time none of the agencies had adopted recommendations, Mr. Devine noted, but all said they would favor keeping students with AIDS in school "unless some extenuating medical condition made attendance inadvisable."

The school officials' next step was to schedule a meeting among the child's attending physician, the school physician, a nurse from the Hemophilia Center of Rhode Island, school officials, the school system's attorney, a social worker from a nearby hospital, and—"importantly," Mr. Devine noted—faculty members who would be teaching the student.

The meeting took place the day before school opened, and began with the student's doctor—who also served as the medical director of the Hemophilia Center of Rhode Island—giving a detailed medical explanation of AIDS. Medical experts and school officials then "fielded questions, and plenty of them," for the next two and a half hours. Superintendent McCarthy's decision after the meeting: "We would allow the student to attend school, but we wouldn't announce that fact—and certainly not the student's name—to the press," Mr. Devine said.

School opened without incident, Mr. Devine reported, and near the end of the first week he determined "it was time to bring the entire school staff into the picture." The child's physician was asked to return, and fifty staff members took part in a lengthy after-school meeting where "the exchange was

frank and often emotional," according to Mr. Devine. But it was also successful, he reported.

"...by the end of the meeting, it was clear the majority of the staff accepted the reassurances of the medical community that the student posed no danger to other students or staff members."

Although the presence of an informed medical expert willing to answer questions for more than two hours at two separate meetings was no doubt of great importance, Mr. Devine said that a "critical factor" in gaining the understanding and acceptance of the entire faculty was the fact that the teachers who would be working most closely with the child had been briefed several days earlier.

"Teachers who would be working directly with the student were secure in their understanding of the situation, and could help others who were hearing the news for the first time to overcome their fears," he said.

Although school officials had decided not to announce to the press that a student in the school had AIDS, word soon leaked out to reporters nonetheless. And the press, too, played a part in keeping the issue from becoming a difficult community problem, Mr. Devine said.

At that time—the close of the first week of school—the superintendent refused to confirm any information, leaving reporters to turn to the school principal.

"I told them I would not confirm the story and suggested they treat unconfirmed rumors carefully," the principal wrote. "They did. I'm convinced that, had members of the press not exercised restraint, the situation could have escalated into a divisive controversy."

But a report at the end of the second week of school in the local weekly newspaper that, according to local health officials, a 13-year-old Swansea boy had contracted AIDS, convinced school officials that, "ready or not, it was time to go public."

The morning after the story appeared, Mr. Devine met with teacher representatives from each grade, and they decided to discuss the issue with the students "in the security of their

Why It Worked in Swansea

In assessing why a potentially volatile situation was "handled so smoothly" in his school, Mr. Devine points to five reasons. The first, he suggests, is the fact that the school year had already begun and the students were attending school when the news became public. School officials thus had an opportunity "to educate and reassure them in an appropriate atmosphere."

Because of this, he suggests, "Many students were able to help calm their parents' fears"—a second reason for the success of the Swansea experience.

"Our students were compassionate, sensitive, and mature in their response to the situation," he wrote. "Not all communities have been so lucky."

The "quality" of the medical experts who addressed the community was yet another asset to school officials, Mr. Devine said. Both the child's physician and the state epidemiologist "brought credibility and common sense to the issue."

Finally, both members of the faculty and members of the school committee (the school board) were "of vital help," according to the principal.

"Teachers conducted themselves in a highly professional manner; without their commitment, the result surely would have been different," he said.

And members of the school committee made a "significant" decision, Mr. Devine pointed out: by refusing to comment publicly on the situa-

tion, and referring all questions to the principal or the superintendent, they were able to keep "any possible political considerations out of the equation."

Mr. Devine closes his account of his school's experience in admitting a student with AIDS with two footnotes. First of all, he notes, all of the students whose parents removed them from school when the news became public have now returned to Joseph Case Junior High School. And, perhaps more importantly, both the school and the community have rallied around the afflicted student, including holding fundraisers to pay for some of his medical expenses. His classmates "treat him like any other student," says the principal, and when he has to stay out of school for any reason, one of the school's "regular" teachers tutors him at home, instead of a special-education substitute teacher.

"Mark has been dealt a very bad deal," Mr. Devine concludes. [The boy's parents have allowed his first name to be released.] "Right now, he's doing extremely well and is in school every day—right where he should be. He has a right to a normal classroom education until such time as his doctors say that no longer is possible. To deny him that right would further victimize a young man who deserves a much better lot in life." ■

own classrooms." Teachers at this point were "well informed and prepared to face the issue in class," according to the principal. "And because our students are young adolescents, we believed they could handle the announcement better in small groups, rather than in a large assembly, where emotions might get out of hand."

School officials' next concern was the parents of the students. That same morning, two parents arrived and "promptly removed their

children," according to Mr. Devine. "Many" other parents called for "reassurance;" school officials told each caller that the "best person" to turn to for medical information was their pediatrician or family doctor.

"And sure enough, the Swansea medical community responded with just the kind of reassurance most parents sought," Mr. Devine reported.

School officials then announced they would hold a meeting for parents the following week; privately

they hoped "to use with parents the same education process that had worked so well with teachers," Mr. Devine wrote.

Success in this endeavor, they determined, "depended on maintaining control over the situation and helping the public understand it."

The central issue concerning parents, as Mr. Devine described it, was: "Would a boy who had contracted AIDS through a transfusion pose a health hazard to anyone in the school?" Going into the meeting with the parents, school officials had two important factors on their side: the medical experts' opinions that he posed no risk, and "the fact that the victim is an intelligent, responsible, and capable student."

Control of the press, both before and during the meeting, was part of the school officials' strategy during this time.

Members of the press had "free access" to both the superintendent and the principal, but were barred from videotaping or interviewing either in the school or on the school grounds. At the parents' meeting, only one television camera was allowed inside; photographers were confined to one area of the room; and other members of the press were asked—via written rules distributed before the meeting—to remain in the seats designated for them during the meeting. "We were determined this meeting wouldn't be turned into a circus," Mr. Devine explained.

The meeting too was defined by "simple but firm ground rules," he said. To open the meeting, members of a panel composed of Superintendent McCarthy, the boy's physician, the state epidemiologist, and a representative from the state education department each read a brief statement. Parents were then able to direct their questions to the panel through Mr. Devine, who served as moderator.

"It soon became obvious that most of the parents had come to learn," the principal said of the session, which lasted more than three hours. "The few who tried to promote hysteria generally were disregarded by the others."

The next morning, with reporters waiting at the school as school buses arrived, school officials braced themselves—and found "no demonstrations, no boycotts, and no hysteria," according to Mr. Devine. Instead, "Many parents called or sent notes to say the meeting had allayed their fears."

The Responsibilities of School District Leaders

No matter how schools and school district leaders may differ from community to community, they all have many of the same responsibilities when confronted with persons with AIDS in their schools. Among these are:

- An obligation to make education available, if the victim is a student, or to respect the contractual rights of employees, if the victim is a member of the school staff;
- Protection of other students and staff members from health risks;
- Protection of the affected person, if he or she remains in school, from any further health risks;
- Respecting the afflicted person's right to privacy and medical confidentiality, while at the same time
- Providing sufficient information to school staff, parents and students to prevent protests based on suspicion and fear;
- Abiding by existing recommendations from state agencies on admitting persons with AIDS to the schools;
- Coordinating statements from state and local public officials so that the public does not receive conflicting information;
- Establishing cooperation among a wide group of persons, including state and local public health officials, local school board members and school officials, school staff, students, parents and the news media; and
- Maintaining control of events.

As we have seen, development of a school district policy regarding management of persons with AIDS in the schools is one way for school district leaders to address many of these responsibilities. But the response by school district leaders in the Swansea (MA) Public Schools

to a student with AIDS should suggest to school leaders elsewhere that some districts can succeed in admitting students or employees with AIDS to the schools without a formal policy in place.

Of course, not all districts will be as fortunate as Swansea in successfully admitting a student with AIDS to school. From Mr. Devine's description of his district's experience, it appears that, although they had no formal AIDS policy, school district leaders in Swansea were helped in their efforts to admit the student with AIDS by two essential factors.

First, they received expert advice and information about AIDS from federal and state health and education officials. Second, they had a keen understanding of many of the different elements of the community—teachers, students, parents, the local medical community, and the press—and how each of these groups would behave under certain circumstances.

Without information on AIDS from education and health experts, Swansea school officials would have had little sense of how to proceed with respect to educating the student with AIDS. Without a strong understanding of their community, furthermore, school officials would have had little hope of maintaining control of the situation, once they decided how to proceed.

Lessons from Swansea

The lessons school district leaders can learn from the Swansea experience, then, may be (1) to develop an awareness of the issues AIDS can raise in their schools and community, and (2) to have a mechanism of some kind available that will allow them to present the community with their response to these issues in a calm and rational way.

Such a mechanism may not be a formal school board policy, but it should be the basis for any policy, if one is developed. As in Swansea, school leaders of other districts should know best what mechanisms will work in their community: a formal board policy; a less formal board position; or even something as seemingly simple as an understanding, gained through board discussion sessions, of the actions the board will take should a student or an employee

develop AIDS or infection with the AIDS virus.

Whatever the mechanism, it should provide school leaders with a means of addressing the responsibilities outlined above. In particular, the mechanism should enable school district leaders to keep command of the situation, instead of allowing the fears of parents or community groups to create an outbreak of hysteria which will make any leadership by school officials impossible. According to Harold Devine, principal of Joseph Case Junior High in Swansea, "Success depended on maintaining control over the situation and helping people to understand it."

In other communities, development of a board policy or a board position can give school leaders a chance to get to know better the positions of various interested community groups, such as parents, public health officials, and social service representatives. As Ms. Brainerd of the Connecticut state education department noted, successful policy development involves just such a dialogue between school district leaders and community groups.

A Leadership Role

But the "evolution of understanding" between school leaders and community groups that Ms. Brainerd speaks of does not mean that school leaders should relinquish control of the situation and their response to it. Dr. Myers, the Indiana health commissioner, said as much at the NSBA forum when he noted that school boards confronting the issue of AIDS in their schools "ought to take a leadership role rather than letting yourselves be led"—a process which he suggested includes both addressing the issues "in an up-front public way" and "following through on what you're going to do rather than letting circumstances dictate which way you're going to go."

In explaining his theory, Dr. Myers echoed the lessons that the Swansea experience provides school district leaders: development of such a leadership role, he suggested, depends heavily on school leaders acquiring a comprehensive awareness of the issues that AIDS raises for them and for their community.

"I feel that if you get a handle on this early and you learn from some of the successes and failures in other parts of the country, then you are going to put yourselves in the best position in your state to handle these issues over time," Dr. Myers suggested.

Developing a Curriculum for AIDS Education

Just as important as development of a school board policy or a board position with respect to management of persons with AIDS in the schools is development of a curriculum to teach students the facts about the disease and ways to prevent its transmission, medical and education authorities say. And, in addition to teaching students about AIDS, these experts suggest, school districts should develop programs to instruct staff and parents about the disease.

Medical experts at the NSBA forum, for example, were united in their call for schools to develop educational programs about AIDS for teachers, students, and parents. In the absence of a cure or vaccine, they agreed, education is the primary "weapon" against AIDS.

But one speaker at the NSBA forum—although she agreed with the need for such programs in schools—raised a question that is at the heart of efforts to develop AIDS curricula: Are those school districts that have yet to adopt comprehensive sex education courses ready to develop education programs on AIDS, which is a sexually transmitted disease?

"One of the things that we've run up against, through the Parent-Teacher Associations throughout the country, is that there has been great resistance on the parts of local boards of education—indeed, state boards of education—in introducing sensitive matter, nowhere near as sensitive as AIDS has become, as part of the general curriculum" said Manya Ungar, a forum panelist and a P.T.A. representative from Scotch Plains, New Jersey, who is also a second vice president of the national P.T.A.

A Checklist for School District Leaders

Health and education officials suggest six key steps school district leaders should follow in addressing the issue of AIDS in their schools:

- **Work with Local and State Health Officials**
who have a knowledge of communicable diseases and other medical issues that school leaders may lack.
- **Develop and Adopt a Policy Concerning Management of Persons with AIDS**
after consulting with other interested community groups. This policy may be part of a general policy on communicable diseases, and may contain information on hygienic procedures to be followed to prevent the spread of infection in schools. Health officials can provide assistance here, and in steps three through six below.
- **Institute a Public Education Program**
to inform school staff, parents, and other members of the community of the facts about AIDS, as well as the district's policy on persons with AIDS in the schools.
- **Design a Student AIDS Education Program**
to teach students both the facts about AIDS and behaviors to practice to keep free from infection. Secure permission from parents of enrolled students.
- **Respect Privacy Rights of Infected Individuals**
by revealing their identities to as few school staff as is necessary. With infected students, these persons might be the principal, the school nurse, and the student's primary teacher.
- **Take a Leadership Role**
in community reaction to the presence of persons with AIDS in the schools. Control events instead of being controlled by them, by calm presentation of the facts to the public. ■

“We have tried for twenty years to encourage state legislatures, and of course local school boards, to adopt a comprehensive K-12 health and education program that would encompass sex education [or what we] euphemistically call Family Life,” she said.

Dr. Woodrow Myers, the Indiana state health commissioner, concurred with Ms. Ungar that, while AIDS education is necessary, many schools may be reluctant to develop such programs, for the same reasons that they shy away from adding sex education courses to their curricula. But such reluctance by school officials, he contended, does great harm to the students those schools are educating.

“Our society has traditionally been, in my opinion, very uncomfortable in dealing with its own sexuality,” he said. “And, in my opinion, as a state health commissioner, that just has to change; because it’s not just AIDS, it’s gonorrhea, it’s syphilis, it’s chlamydia—there are many, many diseases that young people are getting that are sexually related diseases, and if we spent more time on them in school, we would save them significant amounts of morbidity [illness] and now some mortality.”

“It’s going to be incumbent upon folks in this room, in the school board setting, to really seriously question past policies of not wanting to put Family Life curricula . . . into the school setting,” he said.

Given existing societal “discomfort” with discussing topics related to sex, however, Dr. Myers suggested that one way to teach students about AIDS is to “interject within the health education curriculum information about AIDS, and about many of the other sexually transmitted diseases.”

Dr. Myers is not alone in thinking that AIDS education can become part of classes other than sex education. Several education analysts also have suggested that issues related to AIDS can be taught in classes that have little to do with either sex or health education.

Information about the AIDS virus and means of transmission, for example, can be taught in general science

or biology classes. The social effects of AIDS—on those infected with the virus and on family, friends, and others—can be considered in psychology classes. The civil rights of those person with AIDS can be considered in such classes as civics and history, while recent developments concerning the disease—scientific and legal—can be reviewed in current events classes.

Furthermore, those planning a curriculum that includes AIDS instruction should not forget that in addition to being transmitted sexually, the AIDS virus can be transmitted by certain activities associated with drug abuse. Drug abuse prevention classes or workshops, then, should include a component on AIDS, with emphasis both on the consequences of the disease and on the fact that the virus that causes AIDS can be transmitted through sharing an intravenous needle or syringe with an infected individual.

Resistance to Change

James Price, a professor of health education, public health, and human sexuality at the University of Toledo in Ohio, agreed with the forum speakers that most schools in this country have failed to develop curricula for AIDS education. However, he offered another reason for this phenomenon, separate from a societal reluctance to discuss matters related to sexuality.

The failure of many districts to respond to the need for AIDS education, Dr. Price argued in a recent telephone interview, reflects the tendency of schools systems to be slow in addressing most school health problems.

“If school systems wait for the disease of the year to come along, then take two years to decide what to do about it” before developing a response, he suggested, they will be “five years behind” the disease.

“And that’s where we are now with AIDS,” he said, because the disease first became a problem in U.S. society in 1981.

Even those school districts that already have family life or other sex education courses in place, however, may experience problems when contemplating an AIDS education curriculum. State or district guidelines

that recommend development of such a curriculum may conflict with previously adopted state laws or regulations governing curriculum subject matters. Officials in the Montgomery County (MD) school district faced just such a dilemma last fall, when reviewing proposed state guidelines for district AIDS policy and curriculum development.

In an October 1985 letter to Maryland state health officials responding to the state’s proposed guidelines for management of children infected with the AIDS virus, Montgomery County school officials noted, “There is a statement in [the Maryland State education law governing family life programs]: ‘At no time shall erotic techniques of human intercourse be discussed.’”

In providing the AIDS education that the state proposed in its AIDS guidelines, the officials asked, “Can we discuss various methods of disease transmission . . . or the use of prophylactic measures without violating existing regulations? Can we present information about sexual transmission of [the AIDS virus] without submitting all materials to our lengthy family life and human development approval process?”

“Can we provide information without requiring signed parental consent?” the county school officials continue. “Can we provide information about ‘safe sex,’ limiting numbers of sexual partners, and avoiding certain types of kissing?”

“These are important facts for all staff, students and parents to know,” the Montgomery County officials concluded.

AIDS Education Efforts at the District level

In spite of the reluctance of many school districts to undertake AIDS education, several districts throughout the country already have developed AIDS curricula or other education efforts aimed at spreading information about the disease and disease prevention among students, staff, and parents.

New York City was among the first school districts in the country to introduce an AIDS education curriculum [see box, page 52]. New York

New York City's AIDS Education Curriculum

New York City was among the first school districts in the country to introduce an AIDS education curriculum. Instruction for the city's approximately 300,000 high school students began in the winter of 1986, following teacher education workshops, with junior high school students scheduled to receive instruction in the fall of 1986, according to Sylvia Schechter, director of health, physical education, and school sports for the city schools.

The AIDS curriculum has been incorporated into the existing family living and sex education curriculum which is a component of the district's health education courses. The AIDS curriculum was developed by members of Ms. Schechter's staff in conjunction with the city department of health, and medical experts in the city health department approved the curriculum before it was introduced.

The curriculum consists of two lessons for high school students (grades 10-12, with some schools including ninth grade) and two lessons for junior high school students (grades 7-9 at most schools). Schools are free to "plan and implement their own design" of the classes, according to information accompanying the curriculum; however, all schools are encouraged to develop small-group instruction.

"Schools are free to alter the curriculum in terms of strategy, but not in terms of information," explained Ms. Schechter in a recent telephone interview. "We feel that these are the facts, and it's very important to get them across."

In both junior and senior high school classes, schools are urged to present the materials by either dividing physical education classes into classroom-sized groups; by having health education teachers provide the instruction in other subject-area classes; or by providing instruction in physical education classes in the school gymnasium.

The curriculum materials include a sample parental approval letter which allows parents to have their children excused from the classes. Less than 50 parents of high school students throughout the system asked to have their children excused from AIDS instruction classes, Ms. Schechter noted. Some schools offered an AIDS workshop for parents, although turnout for the workshops was "relatively low," she said.

The Junior High School Curriculum

The concept behind the junior high school curriculum is that "sexual health care is the responsibility of each individual." In this curriculum, the aim of the first lesson is to answer the question "What is AIDS?" by having students be able to identify the cause of AIDS and describe its symptoms.

The aim of the second junior high school lesson is: "Who gets AIDS, and how?" At the end of the lesson, students should be able to identify who is at risk for AIDS and explain how the disease is transmitted, according to the curriculum.

Activities include asking students if they think they can become infected, and why or why not, and listing some myths and facts about AIDS on the chalkboard. Some of these are: "If you play with a child who has AIDS, you will get AIDS" and "Early symptoms of AIDS may be similar to those for a severe cold."

In response to the question "How is AIDS spread?" the activity sheet accompanying this lesson states: "The most common way of contracting the HTLV-III virus is through sexual intercourse with an infected person. The other common way of transmitting the virus is through sharing needles contaminated with infected blood when injecting drugs."

The High School Curriculum

The concept behind the high school AIDS curriculum is that "sexual health requires responsibility to oneself, one's family, and society," according to the curriculum materials. The high school curriculum covers in its first lesson most of the material covered in the two junior high lessons. The second high school curriculum then considers civil rights issues raised by AIDS.

The first lesson for high school students in this curriculum is based on the question "What is AIDS and how is it transmitted?" At the end of the lesson students should be able to identify the cause of AIDS, discuss the symptoms, list the risk groups, and identify ways to avoid contracting the virus, the curriculum outline states.

The second high school lesson asks "What are some of the problems raised by the HTLV-III screening test?" with the objective of enabling students both to summarize some of the civil rights issues involved in administering the test, and to explain why the city health department "finds that the general public would receive no benefit from public identification of people with AIDS or of people exposed to the HTLV-III virus."

Support Materials

Supporting materials for teachers accompanying the curriculum include lists of several AIDS hotline numbers, speakers, AIDS information groups in the city, and a 25-page booklet, prepared by the city health department, that describes the disease, its transmission, the test for the presence of AIDS virus antibodies, and a discussion of "AIDS in the School Setting." ■

City high school students received AIDS instruction in the winter of 1986, with junior high school students slated to receive similar instruction in the fall of 1986. School officials designed their curriculum with the help of city public health officials, and have since received a number of requests for information about the curriculum from other districts throughout the country.

The Los Angeles school board voted last October to have all schools in the district teach students about AIDS, with instruction—geared to age level—extending from elementary grades through high school and subject to parental permission.

Last December, the Minnesota Department of Education, in conjunction with the School Nurse Association of Minnesota, released a comprehensive "resource guide" for inservice education on AIDS and its implications for schools.

In February, the Philadelphia public schools distributed 225,000 booklets on AIDS to staff, students, and parents, at a total cost of \$25,000.

The Dade County (FL) schools plan to begin AIDS instruction during the 1986-87 school year, under a curriculum approved by the county's School Health Advisory Commission, Health Planning Council, and the Department of Public Health, subject to its being updated each year. The proposed curriculum includes a week-

long course component on AIDS in 10th-grade life management courses.

AIDS Curriculum Design

Those who have experience designing AIDS curricula suggest that studying the curricula of other districts is one good way to begin planning one's own curriculum. Before designing their own AIDS educational programs, school district leaders might want to consider such questions as:

- What age group will be taught?
- Where will the instruction take place (e.g., in sex education classes, in health education classes, in physical education classes, or in other classes)?
- Will instruction be in large or small groups?
- Which teachers will have responsibility for instruction?
- Will outside speakers—such as local physicians with knowledge of AIDS, epidemiologists, or public health officials—participate?
- Will schools have a contact person to whom students can go with questions about the disease after they receive AIDS instruction?
- Will parental permission be required?
- What kind of courses in AIDS education will be offered for parents and other members of the community?
- What kind of instruction—inservice or otherwise—will be given to teachers and other staff personnel?

An AIDS curriculum—for students, teachers, or for parents—might include consideration of such basic issues as:

- What the disease is (including an explanation of what 'AIDS' stands for);
- The four means by which the virus is transmitted;
- Who is most at risk for developing AIDS;
- Preventing the spread of the virus; and
- Common myths about AIDS (for example, that the AIDS virus can be transmitted through casual contact).

With older students and adults, AIDS instruction could also include a discussion of the legal and ethical issues the disease raises, such as use of the test for the presence of AIDS virus antibodies as a screening device; discrimination against AIDS victims on the job, in school, or elsewhere; and the origin and growth of AIDS panic.

Those school officials who have already developed AIDS curricula suggest that district officials should also: seek advice from public health departments and medical experts before developing a curriculum; allow time for public review of materials; and provide training in AIDS instruction to school staff, with the help of local public health officials. ■

CONCLUSION:

AIDS and Crisis Management

Educators, medical, and legal experts all agree that AIDS is a critical health and social issue facing school districts today, and that policy decisions concerning management of persons with AIDS in schools should be made expeditiously—preferably before a district is faced with a student or employee who has AIDS.

But although development of policies that can address such situations is critical, some education analysts suggest that discussions about AIDS in the schools should also take place in the broader arena of "crisis management;" that is, the ability of a school district to maintain control in any kind of crisis when public opinion is aroused: be it AIDS or textbook controversy or a school closing.

As Dr. Cooper of St. Luke's-Roosevelt Hospital Center in New York City put it at the NSBA forum, the issue of AIDS can be "an extreme challenge to that community's capacity for conflict resolution," as well as "a measure of the levels of trust and distrust within and among communities."

In a study of school and community relations, staff at the Center for the Study of Local Government in St. Cloud, Minnesota, concluded that: "People are increasingly critical of how their social institutions, including their schools, perform. To a significant degree, this dissatisfaction is caused when people receive incomplete, poor or misleading information on what is being done and how decisions are being made. If the cycle of poor communications is not broken, decision-makers will more often find themselves in a defensive position facing a public that is more openly critical."

A look at those districts where admission of a student with AIDS caused the most controversy reveals that, in this respect at least, the issue of AIDS is no different from many other controversial issues with which schools are faced.

In districts where controversy erupted, lack of communication among public officials—and between public officials and the public—contributed to public anxiety. In

communities such as Springfield, Missouri, and Swansea, Massachusetts, on the other hand, school officials prepared the public to accept the student with AIDS by methodically disseminating information, with the assistance of medical experts, to as broad a spectrum of people as possible.

Comparisons among districts are admittedly of limited value, because groups of individuals—and their reaction to the same issue, even if it is presented in an identical way—can vary greatly from community to community. As Indiana's Dr. Myers said at the NSBA forum, "It's very, very difficult to convince individuals who don't seem to want to be convinced or aren't in the mood to be convinced, with respect to scientific information."

But it is nonetheless true that lack of information in understanding AIDS greatly increases public anxiety both about the disease and how it is spread, and about the competence of the public officials involved.

As the judge in the New York City case said, "Instead of educating and inspiring the confidence and trust of the public, [the officials involved] left them frustrated and hostile in the face of such an emotionally charged issue. It is these public officials themselves who predictably, although perhaps unwittingly, let loose the forces of anxiety and fear."

And once aroused, public uneasiness about AIDS—or about any issue—is not easily laid to rest. As Dr. Silverman pointed out at the NSBA forum, the earlier the information is disseminated, the smaller is the chance that public concerns can develop into public hysteria.

"What you need to do if you feel a headache coming on or if you have a problem with certain pain is to take the painkiller early, because the effectiveness of the painkiller goes down as the pain increases," Dr. Silverman said. By the same token, he continued, communities need to "talk about the issue before it's an issue, when people aren't already massed on different sides of the fence, and discuss it in a dispassionate and objective way."

“If we wait until the crisis hits our community,” he suggested, “the effectiveness of education and information is going to be minimal.”

The exercise of developing a policy on AIDS, then, should also be a time for school boards to examine their mechanisms for handling any crisis. Such questions can include: Is leadership at the district level clearly defined? Are links with necessary state education and other state officials clearly delineated? What about relations with other local officials, such as the public health officer? What is the state of relations with the local news media? Has the district developed a community relations program, and put it into practice?

A review of those school districts who successfully admitted students

with AIDS shows they succeeded in three areas which might be expected to be present in other situations of crisis for schools:

- They provided necessary information, at a time when people—school staff, parents, and the general public—were capable of assimilating it;
- They balanced needs: in this case, the need of the student for an education with the need of other students and staff not to have their health jeopardized; and,
- Perhaps most importantly, they maintained control of the situation and the various players involved.

School boards will always face criticism from the public: they are public officials, they handle public funds, and—a fact that may make their role more sensitive than

that of other public officials—their decisions directly affect the development of our country's children and youth.

But how a school district responds to crisis is a measure of its worth, analysts say—because those school boards who show themselves able to be paralyzed by a crisis severely test public confidence in their ability to handle their responsibilities in times of relative calm.

Those districts where AIDS has divided a community can thus serve as a lesson to school officials, as Dr. Myers pointed out. Rather than saying, “It can’t happen here,” school officials—by developing a well-balanced crisis management policy—can say, “We won’t let it happen here.” ■

About NSBA...

The National School Boards Association is located in Alexandria, Virginia, within the Washington, D.C., metropolitan area. NSBA is a not-for-profit organization whose primary mission is the general advancement of education through the unique American tradition of local citizen control, whereby public elementary and secondary school policy is decided by local school board members who are directly accountable to the community. Over 95% are elected, and the remainder are appointed by elected officials. NSBA promotes the quality of the public elementary and secondary schools through services to state school boards associations and local school boards; by maintaining liaison with other education organizations and governmental authorities; and by increasing school board influence on federal education laws and regulations.

Federation Members of NSBA are the 49 state associations of local school boards and the boards of education in Hawaii, the District of Columbia and the U.S. Virgin Islands. About 1,900 local districts are NSBA Direct Affiliates.

NSBA represents the interests of school boards before Congress, federal agencies and in court cases relating to education; provides education and training programs for school board members; provides school district management services; and offers to school boards a variety of other services including an annual convention.

NSBA policy is determined by a 150-member Delegate Assembly composed of active school board members from across the country. Translating this policy into action programs is a Board of Directors consisting of 20 members and four *ex officio* members. The executive director administers NSBA programs, assisted by a 100-member staff.

Two NSBA Councils and five committee/conference/forum groups play a significant role in the National School Boards Association:

- Council of Urban Boards of Education
- Council of School Attorneys
- Federation Member Executive Directors' NSBA Liaison Committee
- Large District Forum
- Rural District Forum
- Conference of School Boards Association Communicators
- Forum of Federal Policy Coordinators

NSBA also maintains liaison with other groups, including the National Caucus of Black School Board Members, National Caucus of Hispanic School Board Members, National Caucus of Young School Board Members, National Association of State Boards of Education (NASBE), American Association of School Administrators (AASA), National Conference of State Legislatures (NCSL), and Education Commission of the States (ECS), to mention but a few nationwide organizations influencing education in the U.S.

Three major publications are produced by NSBA: the award-winning monthly magazine, *The American School Board Journal*; the monthly magazine, *The Executive Educator*; and the bi-weekly newspaper, *School Board News*.

Founded in 1940, NSBA had its first offices in Chicago and later moved to suburban Evanston, Illinois. In 1968, an Office of Federal Relations was established in Washington, D.C., and 1976 the entire NSBA operation moved into consolidated offices in Washington, D.C. In May, 1984, NSBA moved into newly-constructed, wholly-owned offices in Alexandria, Virginia.